

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

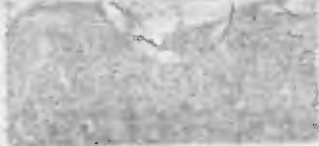
Item 2 & 7 will be 3381 7-26-67 kk

09671

CERTIFICATE OF DEATH

09676

1. PLACE OF DEATH a. COUNTY <u>Potomac Valley N. H. County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert E. Adams</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1891</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accounting</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Adams</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>374-16-3082</u>	
17. INFORMANT <u>Betty Berry</u>		Address <u>Red Barn La., Potomac, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minute</u> <u>unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema & Fibrosis; Chronic Bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1967</u> to <u>7-7-</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 30, 1967</u> , and that death occurred at <u>2 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Francis J. Murray</u>		22b. DATE SIGNED <u>7-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS J. MURRAY</u>		22d. ADDRESS <u>1601 18th St NW Wash DC 20009</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Detroit, Michigan</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REG'D BY REGISTRAR <u>BETHESDA, MARYLAND</u>	
25b. REGISTRAR'S SIGNATURE <u>JUL 13 1967</u>		DATE	



UNITED STATES

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UNITED STATES DEPARTMENT OF AGRICULTURE

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Cover, John baby, 18, mtd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09672

CERTIFICATE OF DEATH

09677

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 151 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DOROTHY A ALVANS		4. DATE OF DEATH Month 7 Day 12 Year 1967		9. AGE (In years lost birthday) yrs. 75	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 5/18/92		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ERNST GENTZEL	
14. MOTHER'S MAIDEN NAME Dora Schoeler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO.		16. SOCIAL SECURITY NO. 579-32-9922	
17. INFORMANT DAUGHTER: DOROTHY PELUSO		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 490X IMMEDIATE CAUSE (a) Bilateral necrotizing lobes pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH 4 days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) leukemia					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from July 11, 1967 , to July 12, 1967 , that (I) (we) last saw the deceased alive on July 12, 1967 , and that death occurred at 5 P.M. from causes and on the date stated above.			
22a. SIGNATURE Sydney Leventhal		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 13, 1967	
22c. PHYSICIAN'S NAME (Type) Sydney Leventhal M.D.		22d. ADDRESS Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/12/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION (City or town) (County) (State) Prince George Co., Maryland		24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland			
25a. REC'D BY REGISTRAR JUL 17 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...			

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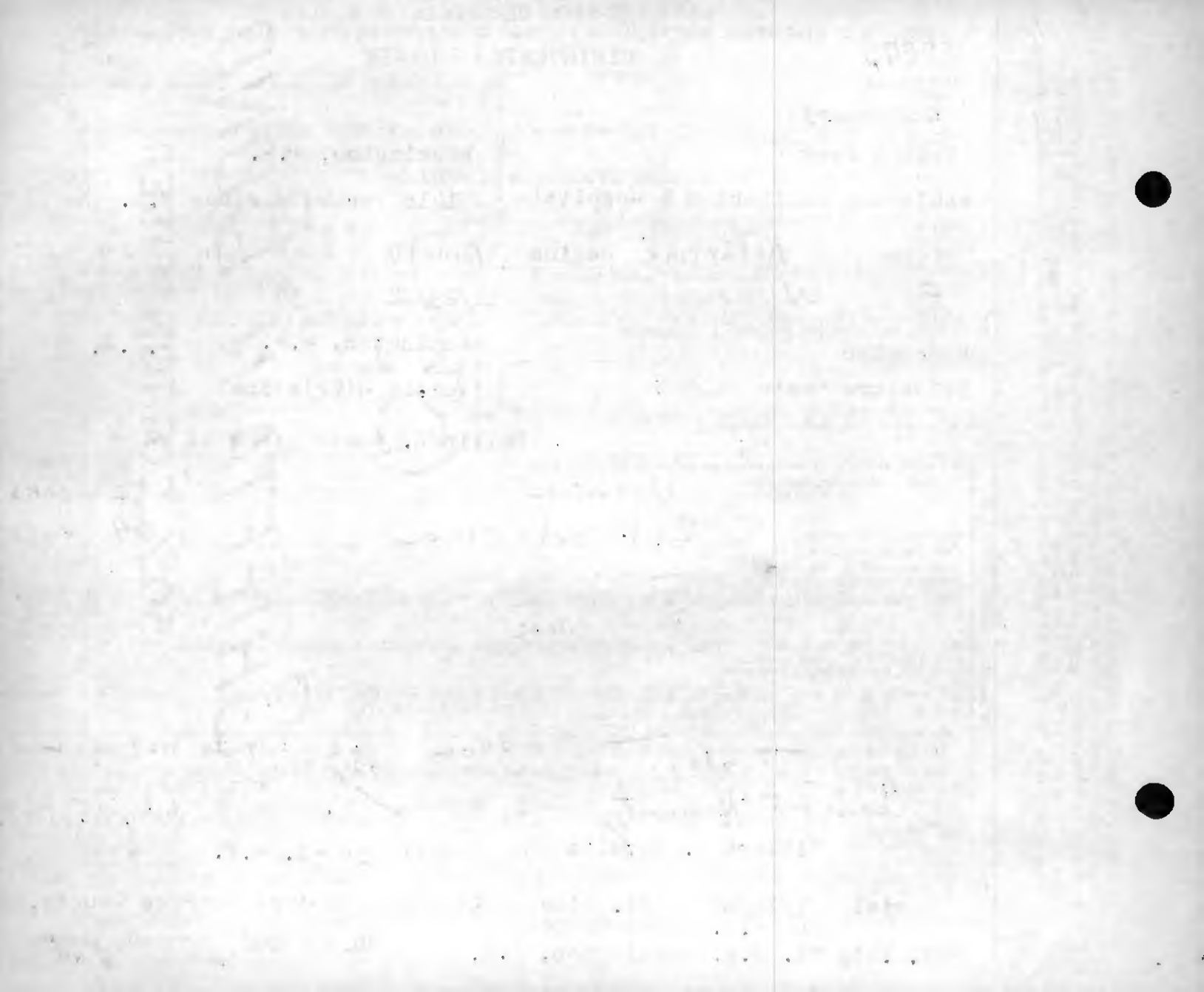
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09673
CERTIFICATE OF DEATH
09673

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 1416 Parkwood Place N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle Regina Last Amato		4. DATE OF DEATH Month July Day 24 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/08
9. AGE (In years last birthday) 58 yrs.		10. FUND 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salvatore Amato		14. MOTHER'S MAIDEN NAME Teresa DiCristina	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT Philip J. Amato		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Scleroderma DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 1963, to July 24 , 1967, that (I) (we) last saw the deceased alive on 7/24 , 1967, and that death occurred at 4:20 p.m., from the causes and on the date stated above.			
22a. SIGNATURE Gilbert E. Hurwitz		22b. DATE SIGNED July 25, 1967	
22c. PHYSICIAN'S NAME (Type) Gilbert E. Hurwitz		22d. ADDRESS 1800 Eye St. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/27/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges County, Md	
24. FUNERAL DIRECTOR The S.H. Hines Company		25a. REC'D BY REGISTRAR JUL 26 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...		25c. ADDRESS 2901 14th St. N.W. Washington, D.C.	



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09674		09679	
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN TB <u>4 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DISTRICT of Columbia</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>473</u> d. STREET ADDRESS <u>5000 MILLWOOD LANE N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAFFA B. AWALT</u>		4. DATE OF DEATH Month Day Year <u>July 8 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/94</u> 9. AGE (In years lost birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GILBERT A. HASLUP</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA M. TURNER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W.I</u>	
16. SOCIAL SECURITY NO. <u>579-60-9282</u>		17. INFORMANT <u>FRANCIS GLOYD AWALT, JR.</u> Address <u>5000 MILLWOOD LANE N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination due to varices</u> DUE TO (b) <u>Esophageal varices</u> DUE TO (c) <u>Cirrhosis of the liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>5810</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>6 yrs</u> <u>12 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr</u> , 19 <u>61</u> , to <u>7 July</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>7 July</u> , 19 <u>67</u> , and that death occurred at <u>7:45</u> A.M., from causes and on the date stated above			
22a. SIGNATURE <u>Herbert Martyn Jr.</u>		22b. DATE SIGNED <u>8 July 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR.</u>		22d. ADDRESS <u>4740 Chevy Chase Dr.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-11-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wise Ave. N.W. Wash. DC.</u>		25a. REC'D BY REGISTRAR <u>JUL 13 1967</u> REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

THE UNIVERSITY OF CHICAGO

DEPT. OF CHEMISTRY

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RECEIVED

1911

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TO THE UNIVERSITY OF CHICAGO

FROM THE UNIVERSITY OF CHICAGO

1911

TO THE UNIVERSITY OF CHICAGO

FROM THE UNIVERSITY OF CHICAGO

1911

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delays necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 391 8-3 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G391 7/31/67 ph

09675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09680

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b - DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL D.O.A.					d. STREET ADDRESS 3904 NICHOLSON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last BRYANT - BAGWELL				4. DATE OF DEATH Month Day Year 7 24 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-26-05	
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION WORKER			10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (State or foreign country) WAKE COUNTY, N. C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME HARDY BAGWELL				14. MOTHER'S MAIDEN NAME ELLA SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 579 10 1853		17. INFORMANT MEDICAL RECORD DEPT. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency with recent 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) and old myocardial infarction; DUE TO (c) Coronary artery heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 7/24/1967
ACTUAL SIGNATURE Belden R. Reap, M.D. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Wheaton (City or town, county or country)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Colmar Manor, Prince Georges, Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. RECEIVED BY REGISTRAR JUL 27 1967 DATE		25b. REGISTRAR'S SIGNATURE [Signature]	

2/27/2024

DOI: 10.1002/for

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VR A15 (4)
20M 1/65

CONFIDENTIAL

5581

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery Co. Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kensington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>3804 Washington St</u>	
3. NAME OF DECEASED (Type or print) <u>Alexander E. Barch</u> First Middle Last		4. DATE OF DEATH <u>July 16 1967</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-05</u> 62 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst Mgr. Mont. Co. Liquor Board</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MICHIGAN U.S.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>FRANK BARCH</u>		14. MOTHER'S MAIDEN NAME <u>SALOME FORREST</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1954, 19</u> , to <u>7/16</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>7/16</u> , 19 <u>67</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u>		22b. DATE SIGNED <u>7/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>		22d. ADDRESS <u>10400 CONNECTICUT AVE KENSINGTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	23d. LOCATION (City, town or county) (State) <u>WHEATON MD.</u>
24. FUNERAL DIRECTOR <u>HANLON FUNERAL HOME WASH. D.C.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JUL 25 1967 Charles Judge</u>	

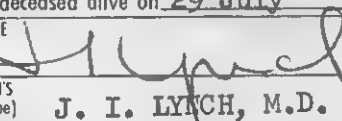
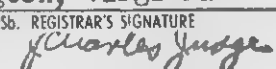
09677

CERTIFICATE OF DEATH

09682

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 2 Days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Washington D. C.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia		d. STREET ADDRESS 4605 47th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lee		First Winthrop		Middle Barnes		Last Barnes		4. DATE OF DEATH Month July		Day 29		Year 1967	
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 July 1967		9. AGE (In years lost birthday) yrs 02		IF UNDER 1 YEAR Months 02		IF UNDER 24 HRS Days 02	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland				12. C TIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John W. Barnes Jr.						14. MOTHER'S MAIDEN NAME Patrica Ellen Davenport							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None				16. SOCIAL SECURITY NO. None		17. INFORMANT John W. Barnes Jr.		Address 4605 47th Street, N.W.		City Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 28 July , 19 67 , to 29 July , 19 67 that (I)(we) last saw the deceased alive on 29 July , 19 67 , and that death occurred at 5:30 PM , from causes and on the date stated above.													
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) J. I. LYNCH, M.D.						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 31 July 1967					
22d. ADDRESS Naval Hospital, Bethesda, Maryland													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8-1-67		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia							
24. FUNERAL DIRECTOR R. A. Pumphrey				ADDRESS 7557 Wisconsin Ave. Bethesda, Md.		25a. REC'D BY REGISTRAR AUG 3 1967		25b. REGISTRAR'S SIGNATURE 					

00678

CERTIFICATE OF DEATH

00683

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>12714 FREDON ST</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>BARNWELL</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-67</u>
9. AGE (In years last birthday) yrs <u>6</u> Min <u>58</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (County & State or foreign country) <u>Montgomery--Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>VINCENT Barnwell</u>	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO <u>-----</u>		17. INFORMANT Address <u>Vincent Barnwell-father-same item # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Premature Neonatal Atelectasis</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>Premature rupture bag of waters</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs 58 min</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>JULY 31, 1967</u> , to <u>JULY 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>JULY 31, 1967</u> , and that death occurred at <u>5 A.M.</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Edward J. Feroli</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward Feroli, M.D.</u>		22d. ADDRESS <u>11250 Rockville Pike Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REC'D BY REGISTRAR <u>Aug 4 1967</u>	
25a. ADDRESS <u>1531 Rock. Pike Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRINGFIELD c. LENGTH OF STAY IN 1b 3 mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5409 CHRISTY DR.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE N.J. b. COUNTY Bergen c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wood-Ridge d. STREET ADDRESS 335 Columbia Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARTHA Middle (NME) Last BARRERE						4. DATE OF DEATH July 29 1967 Day Month Year							
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 27, 1889		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Antoine Lblanche						14. MOTHER'S MAIDEN NAME MARIE Forest							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. 082-10-1636		17. INFORMANT Address John A. Barrere - Wood-Ridge, N.J.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas (b) arteriosclerosis (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 5 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb 7, 1962 to July 29, 1967 , that (I) (we) last saw the deceased alive on July 29, 1967 , and that death occurred at 335 PM , from the causes and on the date stated above.													
22a. SIGNATURE C P Ryland						22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) C P RYLAND						22d. ADDRESS 4400-4981 NW Wash DC 20016							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12 Aug 1967		23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM PK.		23d. LOCATION (City, town or county) (State) PARAMUS, N.J.							
24. FUNERAL DIRECTOR Joseph Gawlers Sons Inc. Wash. DC.						25a. REC'D BY REGISTRAR AUG 2 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00670

CERTIFICATE OF DEATH

05685

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University of Nursing Home, Wheaton, Md.		d. STREET ADDRESS 705 Chillum Road	
3 NAME OF DECEASED (Type or print) First Samuel Middle Squires Last Bartlett		4 DATE OF DEATH Month 7 Day 6 Year 19 67	
5 SEX male	6 COLOR OR RACE Caus.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) post office employee		10b. KIND OF BUSINESS OR INDUSTRY Government	9. AGE (In years last birthday) 75 yrs
11 BIRTHPLACE (County & State or foreign country) Shiloh, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William S. Bartlett		14. MOTHER'S MAIDEN NAME Elizabeth Squires	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 226-48-0998A	
17. INFORMANT Mrs. Louise V. Bartlett (same as above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Cancer metastasis 177X DUE TO (b) Carcinoma prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 12 mos. 72 mts.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/1 , 19 67 , to 7/6 , 19 67 that (I) (we) last saw the deceased alive on 7/5 , 19 67 , and that death occurred at 12:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Harry N. Carlton		22b. DATE SIGNED July 6, 1967	
22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON		22d. ADDRESS 8811 Coloma Rd - S.S. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/8/67	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR The S.H. Hines Company Washington, DC		25a. REC'D BY REGISTRAR JUL 10 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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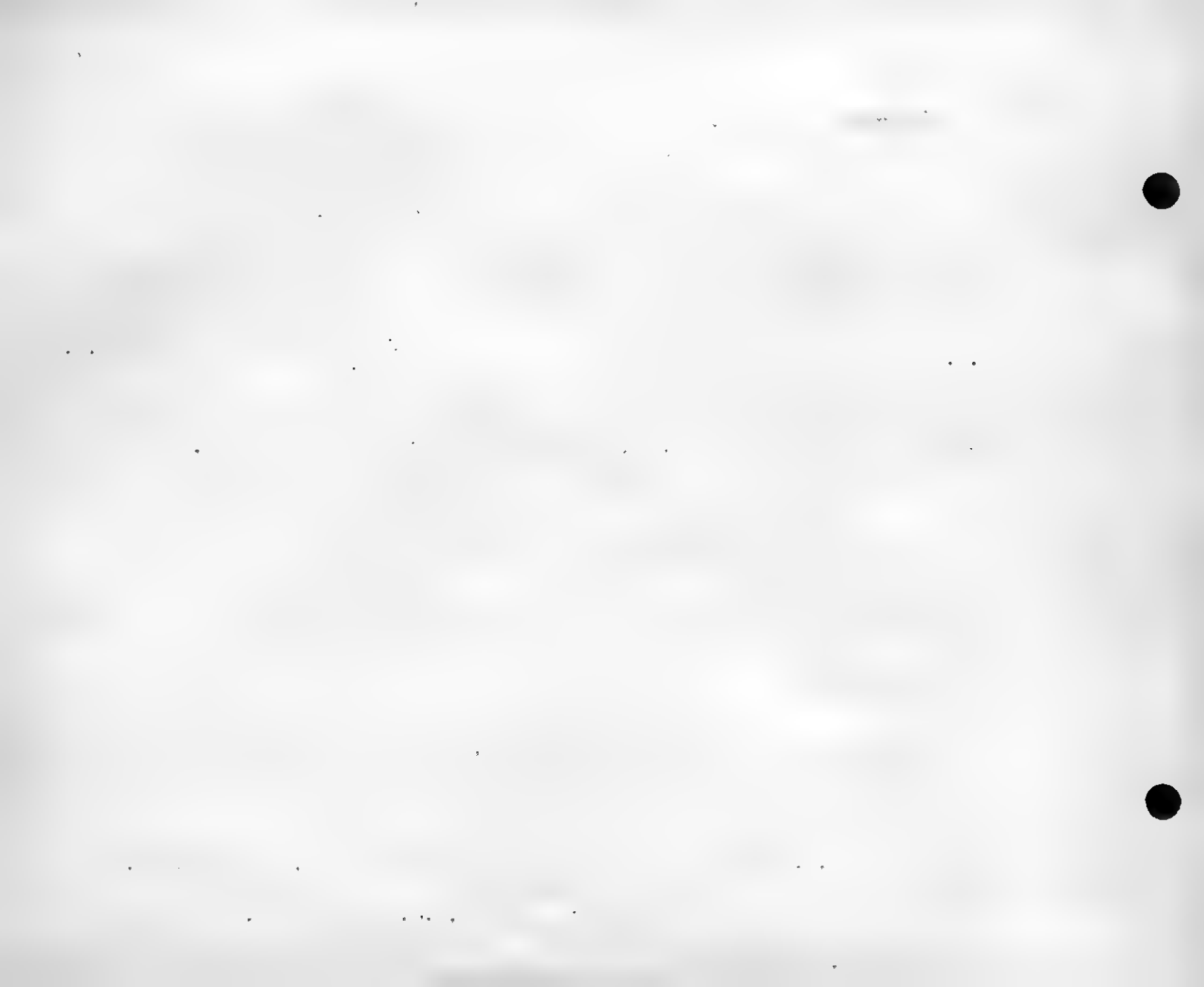
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00081

CERTIFICATE OF DEATH

00686

1 PLACE OF DEATH a. COUNTY Baltimore Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in 1b 13 Mos 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHESDA NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Alfred Middle BASILE Last		4. DATE OF DEATH Month 7 Day 31 Year 67	
5 SEX Male	6. COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 25 July 1916
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Air Force		10b. KIND OF BUSINESS OR INDUSTRY Military	11 BIRTHPLACE (County & State, or foreign country) NEW YORK N.Y.
13. FATHER'S NAME FRANK BASILE		14. MOTHER'S MAIDEN NAME THERESA BRANCO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes UNKNOWN		16 SOCIAL SECURITY NO 155-05-2020	
17. INFORMANT Thomas Basile		Address Westmont 162 Haddon Ave. New, Jersey	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of base of Tongue 1410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last with metastases (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1 June , 19 66 , to 31 July , 19 67 , that (I) (we) last saw the deceased alive on 31 July 19 67 , and that death occurred at 1215P M, from causes and on the date stated above.			
22a. SIGNATURE H.O. Defries		22b. DATE SIGNED 1 Aug 1967	
22c. PHYSICIAN'S NAME (Type) H.O. Defries		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1 AUGUST 1967	23c. NAME OF CEMETERY OR CREMATORY Harleigh, Camden, N.J.	23d. LOCATION (City or Town) (County) (State) Camden, New Jersey
24. FUNERAL DIRECTOR Joseph Bocco, Camden, New Jersey		25a. REC'D BY REGISTRAR DATE AUG 2 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



CERTIFICATE OF DEATH

00682

0687

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Washington D.C. b. COUNTY Washington D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 1125 Spring Road	
3 NAME OF DECEASED (Type or print) Sarah (none) Becker		4 DATE OF DEATH Month July Day 20 Year 1967	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-98
9a. AGE (In years last birthday) 68 yrs		9. IF UNDER 1 YEAR Months 20 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. COUNTRY OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 577-05-8648	
17. INFORMANT Patient's chart		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-28-67 , 19 67 , to 7-20 , 19 67 , that (I) (we) last saw the deceased alive on 7-19 , 19 67 , and that death occurred at 12:45 A.M., from causes and on the date stated above.			
22a. SIGNATURE Abraham W. Danis		22b. DATE SIGNED 7-20-67	
22c. PHYSICIAN'S NAME (Type) ABRAHAM W. DANIS		22d. ADDRESS 1106 SPRING ST SE. MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7-21-67	23c. NAME OF CEMETERY OR CREMATORY CHESED SHEL EMMES CEM.	23d. LOCATION (City or Town) (County) (State) WASHINGTON D. C.
24. FUNERAL DIRECTOR Frederick J. ...		25a. REC'D BY REGISTRAR DATE JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>CALIFORNIA</u> COUNTY <u>LOS ANGELES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANDLER CHASE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEVERLY HILLS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETHESDA SILVER SPRING NURSING HOME</u>		d. STREET ADDRESS <u>649 S. BUENASIDE</u>	
3. NAME OF DECEASED (Type or print) <u>BERBERICK, BARC JESSIE</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 23, 88</u> 78 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N. DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GUSTAVE BERBER</u>		14. MOTHER'S MAIDEN NAME <u>BEILA BARC BARC</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>509-03-6663-D</u>	
17. INFORMANT <u>BETTY FREDERICK</u> Relationship <u>Daughter</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> DUE TO (b) <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>163X</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1967</u> , to <u>7/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> , 19 <u>67</u> , and that death occurred at <u>32</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>7/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. BIG</u>		22d. ADDRESS <u>1641 Colman Rd Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>BURIAL</u>	<u>Aug-67</u>	<u>ROSE HILL Cem</u>	<u>CHICAGO, ILL.</u>
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>4217-9-Dee.</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>AUG 1 1967</u>	

09683

09688

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 in the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hosp.		d. STREET ADDRESS 8007 Eastern Ave	
3 NAME OF DECEASED (Type or print) First Joseph Middle Berger Last Berger		4 DATE OF DEATH Month 7 Day 16 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/19/00
9 AGE (In years last birthday) 66 yrs		10 IF UNDER 1 YEAR Months 7 Days 16 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
11 BIRTH PLACE (State or foreign country) Poland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME MAYER BERGER		14 MOTHER'S MAIDEN NAME KAE SILVERSTONE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO 578-46-4321	
17 INFORMANT CHARLOTTE BERGER (Name as 2nd)		Address (same as 2nd)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency +101 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden K. Neap M.D. MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN K. NEAP M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED July 16, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, or OTHER (Specify) BURIAL		23b. DATE THEREOF 7-18-67	
23c. NAME OF CEMETERY OR CREMATORY Bnai Israel Cem		23d. LOCATION (City or town) (County) (State) Oxon Hill, MD.	
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR JUL 19 1967	
25b. REGISTRAR'S SIGNATURE James J. [Signature]			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cause notified & approved.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10607 Kenilworth Ave. Apartment # 203</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10607 Kenilworth Ave. Apt. 203</u> d. STREET ADDRESS <u>Bethesda, Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Kingsman Berlin</u> First Middle Last 4. DATE OF DEATH <u>July 16 1967</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 14, 1898</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance-Comptroller-Gov't-Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D. C.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S.</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>William B. Berlin</u> 14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Clements</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW I</u> 16. SOCIAL SECURITY NO. <u>WW I</u> 17. INFORMANT <u>wife Helen M. Berling</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Chronic emphysema</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year <u>July 16 1967</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at Work <input type="checkbox"/> at Work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>May 19 1967</u> , and that death occurred <u>11:15</u> A.M. from the causes and on the date stated above.		22a. SIGNATURE <u>John B. Umhau</u> M.D. 22b. DATE SIGNED <u>7/16/67</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN B UMHAU</u> 22d. ADDRESS <u>8805 CONN. AVE. CHEVY CHASE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>7-19-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo. Co.</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>University Nursing Home</u>					d. STREET ADDRESS <u>6505 2nd Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>J.</u> Last <u>BETTES</u>					4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16, 1898</u>		9. AGE (in years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (County & State, or foreign country) <u>London County, Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>James Bettes</u>					14. MOTHER'S MAIDEN NAME <u>Sara Brown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.I</u>		17. INFORMANT <u>Mrs. Cora A. Bettes, (same as #2)</u>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized, severe, with chronic brain syndrome</u> DUE TO (c) <u>undeterm.</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 d.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. — 19 <u>67</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/3</u> , 19 <u>67</u> to <u>7/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/2</u> , 19 <u>67</u> , and that death occurred at <u>1:35</u> p.m. from the causes and on the date stated above.									
22a. SIGNATURE <u>William F. Simpson</u>								22b. DATE SIGNED <u>7/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson, MD</u>				22d. ADDRESS <u>6246 NH Ave NE - DC 20011</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Burtonsville, Md.</u>		
24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll Rd N.W. Wash DC</u>				25a. REC'D BY REGISTRAR <u>JUL 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

00687

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

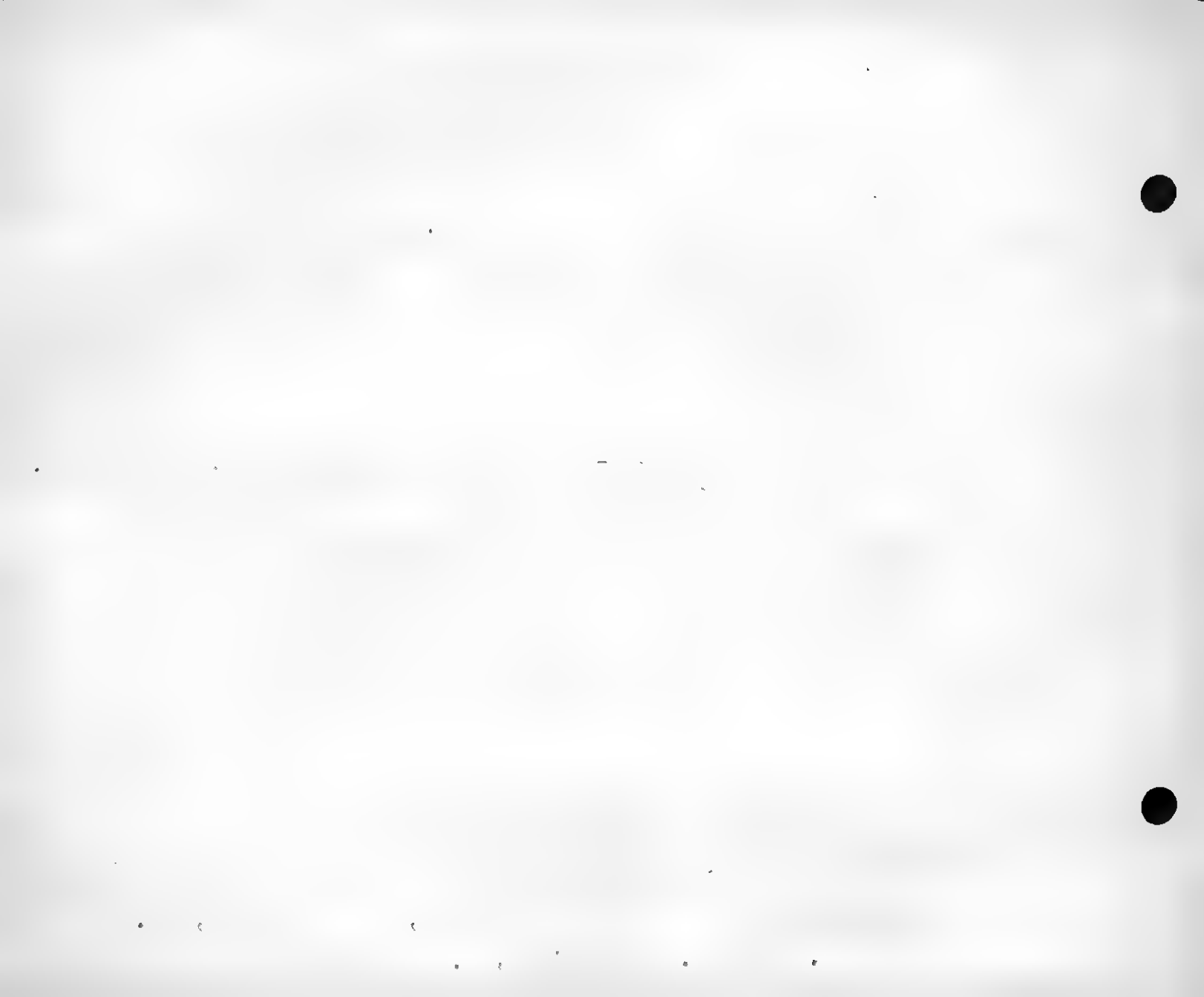
00692

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rural Simpsonville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General</u>				d. STREET ADDRESS <u>Rt. 32</u>			
3 NAME OF DECEASED (Type or print) <u>Lewis Royal Boardley</u>				4 DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>19 67</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11/15/1896</u>	9 AGE (In years past birthday) <u>70</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landscaping</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Bell Boardley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>220-30-3415</u>		17 INFORMANT <u>Medical Records of Montg. General Hospt.</u>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u> </u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				22. DATE SIGNED <u>7/23/1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <u>Charles Judge</u>			
23a. BURIAL REMOVAL <u>BURIAL</u>		23b. DATE THEREOF <u>7-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Church,</u>		23d. LOCATION (City or Town) (County) (State) <u>Highland, Md.</u>	
24. ADDRESS <u>Robert L. Snowden.</u>				25a. REC'D BY REGISTRAR <u>JUL 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>5714 UNIVERSITY BLVD EAST</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 1b					
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bella Vista Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Frances</u>			First Middle Last <u>Brooksie</u>			4. DATE OF DEATH Month <u>JULY</u> Day <u>8</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 3, 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Broad Creek MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James R Edelen</u>						14. MOTHER'S MAIDEN NAME <u>Mary Rober MD</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>577-07-8984B</u>		17. INFORMANT <u>Mr J Arthur Brooksie</u>			Address <u>5821 14th St N.W.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>551X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Atherosclerosis</u> DUE TO (c) <u>Acute Congestive Heart Failure</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 30, 1962</u> to <u>July 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1967</u> , and that death occurred at <u>7:48</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Philip E. Jones</u>								22b. DATE SIGNED <u>7/8/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones MD</u>								22d. ADDRESS <u>800 Pershing Avenue</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>			23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>		
24. FUNERAL DIRECTOR <u>M. J. Thompson</u>				ADDRESS <u>14th St N.W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 12 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 12 hours after death.

Signed with permission of Dr. Paul Brown

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>2 hrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital</i>		d. STREET ADDRESS <i>1810 Arcola Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>Eva</i> Middle <i>Sarah</i> Last <i>Brown</i>		4. DATE OF DEATH Month <i>July</i> Day <i>19</i> Year <i>1967</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 26, 1897</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Hulien</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Lerch</i>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-50-6788</i>	
17. INFORMANT <i>Mrs. Thelma Woodson</i>		Address <i>1810 Arcola Avenue Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 4200 DUE TO <i>Chronic Cardio-Vascular Nephro-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>sclerosis</i> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>24 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>July 18, 1967</i> to <i>July 19, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 18, 1967</i> , and that death occurred at <i>7:57 PM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert C. Haile</i>		22b. DATE SIGNED <i>July 19, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert C. Haile, M. D.</i>		22d. ADDRESS <i>8209 Kerry Road, Chevy Chase, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>July 22, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Washington, D. C.</i>
25a. REC'D BY REGISTRAR <i>Warner E. Pumphrey, Inc.</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Young</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2. These should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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09650

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>4 hrs 55 mins</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>13601 Hoyola St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Genevieve Marshall Brown</u> First Middle Last SEX <u>Female</u> 6. CO. OR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/1/05</u> 9. AGE (In years last birthday) <u>61</u> 10. UNDER 1 YEAR <u>5</u> 19 <u>67</u> 11. MONTHS <u>5</u> 19 <u>67</u> 12. HOURS <u>5</u> 19 <u>67</u> 13. MIN <u>5</u> 19 <u>67</u>				DATE OF DEATH <u>July 7, 1967</u> Month Day Year			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Analyst</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Mo</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Charles H. Marshall</u> 14. MOTHER'S MAIDEN NAME <u>Thelma Jackson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Yes</u> 17. INFORMANT <u>Charles Brown</u> 18. ADDRESS <u>13601 Hoyola St. Silver Spring, Md.</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Melanotic carcinoma breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>170X</u> DUE TO (c) <u>170X</u>				INTERVA. BETWEEN ONES AND DEATH <u>18 mins</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1961 to 7/4, 1967</u> , that (I) (we) last saw the deceased alive on <u>1 July 1967</u> , and that death occurred at <u>5/6/67</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Horace W. Bernton</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>				22b. DATE SIGNED <u>7/5/67</u> 22d. ADDRESS <u>4743 Bradley Blvd., Ch. Ch., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>July 8, 1967</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>				23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>JUL 10 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Juge</u>			

CERTIFICATE OF DEATH

09691

09696

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland c. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 7667 Maple Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last James Alton Bruen, Sr.		4 DATE OF DEATH Month Day Year 7-21-67	
5 SEX Male	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-04
9 AGE (in years last birthday) 63 yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Broker Vice President		10b. KIND OF BUSINESS OR INDUSTRY Floegel, Nolan, Fleming & Co. New York	
11 BIRTHPLACE (County & State, or foreign country) America		12 CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Edward Bruen		14. MOTHER'S MAIDEN NAME Grace Reynolds	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 579-01-9162	
17 INFORMANT Patient's Chart		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Encephalitis of the Liver with Hepatic Coma 5810 DUE TO Asystole (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.) DUE TO (b) Acute DUE TO (c) Hypalbuminemia Anemia			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure (mild), Esophageal Varices, Aortic Stenosis			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Case - type	
20a. AGE DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 6-26 , 1967, to 7-21 , 1967, that (1) (we) last saw the deceased alive on 7-21 , 1967, and that death occurred at 6:25 AM , from causes on and on the date stated above			
22a. SIGNATURE Alan R. Gair		22b. DATE SIGNED 7/21/67	
22c. PHYSICIAN'S NAME (Type) Alan R. Gair M.D.		22d. ADDRESS 7777 Maple Ave, Takoma Park, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/24/67	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or town) (County) (State) Washington, D.C.	
24 FUNERAL DIRECTOR The S.H. Hines Company		25a. REC'D BY REGISTRAR 2901 14th St. N.W. Wash. D.C.	
25b. REGISTRAR'S SIGNATURE JUL 24 1967		25c. REGISTRAR'S SIGNATURE John A. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

03697

09692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if most of last year; if not, residence before admission) a. STATE MARYLAND b. COUNTY HOWARD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 13 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLCOTT CITY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL			d. STREET ADDRESS RT#2, TRIDELPHIA ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE ANDER BURGESS			4. DATE OF DEATH Month Day Year JULY 27 1967		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/1/02	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME FRANK BURGESS			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT MEDICAL RECORDS			Address		
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, INSTANTANEOUS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 15 MIN.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LEFT CEREBRAL THROMBOSIS WITH RIGHT HEMIPLEGIA-13 DAYS DURATION					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7/4/1962 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on JULY 27 19 67 , and that death occurred at 9:30AM , from causes and on the date stated above.					
22a. SIGNATURE <i>Charles S. Whitaker, M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED JULY 27, 1967	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M.D.			22d. ADDRESS ELLCOTT CITY, MARYLAND		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/30/67	23c. NAME OF CEMETERY OR CREMATORY BR OWNS CHAPEL CEMETERY	23d. LOCATION (City or Town) (County) (State) DAYTON, HOWARD, MD.		
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i> ROCKVILLE, MD.			25a. REC'D BY REGISTRAR DATE AUG 4 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09693

CERTIFICATE OF DEATH

09693

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookeville			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First George Middle Albert Last Burroughs				4 DATE OF DEATH Month July Day 22 Year 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-17-89		9 AGE (In years last birthday) 77 yrs	IF UNDER 12 Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Gov.		10b KIND OF BUSINESS OR INDUSTRY Retired		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Burroughs				14 MOTHER'S MAIDEN NAME Barbara Peters			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 212-10-3922		17 INFORMANT Address Medical Records Montgomery Gen. Hospital			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Carcinoma of pancreas DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 months
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb , 1966, to July 22, 1967 , that (I) (we) last saw the deceased alive on July 21 , 1967, and that death occurred at 6:30am , from causes and on the date stated above.							
22a. SIGNATURE A.D. Bonifant				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. A.D. Bonifant				22d. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 7-24-67		23c NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d LOCAT ON (City or Town) (County) (State) Sunshine, Md	
24 FUNERAL DIRECTOR Francis H. Barber Funeral Home				25a REC'D BY REGISTRAR JUL 25 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

00699

00694

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN lb <u>3 DAYS</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAYTONSVILLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>RFD #2</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>BUTLER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 26, 1903</u> 9. AGE (in years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>FRANK DOUSEY</u>		14. MOTHER'S M maiden NAME <u>REBECCA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	17. INFORMANT <u>BERNICE JACKSON</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma ovary with intra-abdominal spread,</u> <u>1/100</u> DUE TO <u>diffuse.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>.</u> DUE TO (c) <u>.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from <u>July 18, 1967</u> to <u>July 18, 1967</u> that (s) (we) last saw the deceased alive on <u>July 18, 1967</u> and that death occurred at <u>2:30 PM</u> from causes and on the date stated above			
22a. SIGNATURE <u>Jules I. Cahana</u> M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE-SIGNED <u>7/19/67</u>
22c. PHYSICIAN'S NAME (Type) <u>JULES I. CAHANA, M.D.</u>		22d. ADDRESS <u>SUBURBAN HOSP BETHESDA MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>July 21, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Emory Grove Montg, Md</u>
24. FUNERAL DIRECTOR <u>George R. Snowden</u>		25a. REC'D BY REGISTRAR <u>Lockwell</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>JUL 24 1967</u>			



CERTIFICATE OF DEATH

09695

09700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages (and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN IL <u>22 days / 7 hours</u>		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>2853 Ontario Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Edwin</u> First <u>(None)</u> Middle <u>Butterworth</u> Last 4 DATE OF DEATH <u>July 29, 1967</u> Month <u>July</u> Day <u>29</u> Year <u>1967</u>		5. SEX <u>Male</u> 6. CO. OR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-3-87</u> 9. AGE (in years last birthday) <u>80</u> yrs IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Clergy</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Pa.</u> 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Butterworth</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mac Caloup</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-50-5201</u> 17. INFORMANT <u>Hospital Records</u> Address <u>2853 Ontario Rd. N. W. Wash. D. C.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Arteriosclerosis obliterans</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>History of tuberculosis in youth - treated</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1967</u> to <u>July 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1967</u> , and that death occurred <u>10:30 p.m.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Kenneth Cruze</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 30, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Kenneth Cruze</u>		22d. ADDRESS <u>831 University Blvd. E., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transit-Burial</u>		23b. DATE THEREOF <u>Aug. 3, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Philipsburg, Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Philipsburg, Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Glen Carter, Glen Carter & Son, Inc., Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 1 1967</u>			



09696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09701

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>9602 Bulls Run Pky.</u>		d. STREET ADDRESS <u>9602 Bulls Run Pky.</u>	
3. NAME OF DECEASED (Type or print) <u>Bonnie Cora Compagna</u>		4. DATE OF DEATH <u>July 24 1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17 1952</u> 9. AGE (in years last birthday) <u>15</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph H. Compagna</u>		14. MOTHER'S MAIDEN NAME <u>Eileen Bryson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO (b) <u>Hanging</u> CONDITIONS (any, which gave rise to immediate cause (a), stating the underlying cause lost) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Hung self on door with bed sheet</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30 p.m. July 24 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>7/24/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>7-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 28 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

09697

09702

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN TB 5 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		e. STREET ADDRESS Park Avenue	
3. NAME OF DECEASED (Type or print) Dolly		4. DATE OF DEATH Month July Day 8 Year 1967	
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/ /91
9. AGE (in years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Montgomery General Hospital records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Toxemia DUE TO (b) Intestinal Obstruction DUE TO (c) Adenocarcinoma, Colon		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/3 to 7/8 , 19 67 , that (I) (we) last saw the deceased alive on 7/7 , and that death occurred 12:27 M, from causes and on the date stated above			
22a. SIGNATURE Charles H. Ligon		22b. DATE SIGNED 7/8/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Ligon, M.D.		22d. ADDRESS Sandy Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/11, 67	
23c. NAME OF CEMETERY OR CREMATORY LINCOLN PARK		23d. LOCATION (City or Town) (County) (State) ROCKVILLE, MONTG. MD.	
24. FUNERAL DIRECTOR Rockville, Md.		25a. REC'D BY REGISTRAR JUL 12 1967	
25b. REGISTRAR'S SIGNATURE J. Edgar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If July 1st is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09695

18703

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda A.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) <u>Suburban</u>		d. STREET ADDRESS <u>3048 - Traymore Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond Campbell Carleton</u>		4. DATE OF DEATH <u>July 31 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1931</u>
9. AGE (In years last birthday) <u>36</u> yrs		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>14</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if it was not a regular occupation) <u>Employ'd service manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO Shop</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>British</u>	
13. FATHER'S NAME <u>James Carleton</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Lingwall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>In English</u>		16. SOCIAL SECURITY NO. <u>219-38-6903</u>	
17. INFORMANT <u>Cecil Norman Bouillon</u>		Address <u>3617 - Traymore Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries, multiple, severe.</u> DUE TO (b) <u>Auto accident</u> DUE TO (c) <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>8164</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Drove car. thru stop street. struck by oncoming car.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4 45 pm 7/31 1967</u>		20d. INJURY OCCURRED <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc) <u>Street.</u>		20f. (City or town) <u>Bethesda Mont.</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 1, 1967</u>	
		Address (Street, city, town, or county)	
23a. CREMATION <input checked="" type="checkbox"/> BURIAL <input type="checkbox"/>		23b. DATE THEREOF <u>8/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) <u>Suitland</u> (County) <u>Md.</u> (State)	
24. FUNERAL DIRECTOR <u>Ritchie Bros. Fun'l Home - Maryland.</u>		25a. REC'D BY REGISTRAR <u>Aug 4 1967</u>	
ADDRESS <u>Upper Marlboro.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

39699

CERTIFICATE OF DEATH

68704

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>7 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>205 S. WASHINGTON ST</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL R. CARR</u>		4. DATE OF DEATH Month Day Year <u>JULY 14 1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/82</u>
9. AGE (In years, last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rockville, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB POSS</u>		14. MOTHER'S MAIDEN NAME <u>APOLONIA DODSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>APOLONIA E. MONDAY - NIECE - S. SPRING</u>	
17. INFORMANT <u>APOLONIA E. MONDAY - NIECE - S. SPRING</u>		Address <u>4412 Bennion Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Recent Myocardial Infarct</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Jay R. Shapiro</u> M.D.		22b. DATE SIGNED <u>JUL 18 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jay R. Shapiro</u>		22d. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/19/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Tyson Wheeler Funeral Home 1331 Rock. Pike</u> <u>Rockville, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

09700

CERTIFICATE OF DEATH

00705

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admn ssion) a STATE West Virginia b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 5 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d STREET ADDRESS 912 Garrison Avenue	
3 NAME OF DECEASED (Type or print) First H. Middle Hobart Last Carrico		4. DATE OF DEATH Month July Day 13 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH April 3, 1897
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technician (Retired)		10b KIND OF BUSINESS OR INDUSTRY W.Va. Univer.	9. AGE (n years lost birthday) yrs 70
11. BIRTHPLACE (County & State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Carrico		14. MOTHER'S MAIDEN NAME Mary Britten	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 1		16 SOCIAL SECURITY NO. WW 1	
17. INFORMANT Lula Craig Carrico		Address Morgantown, W.Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a). 5 days stating the underlying cause last (b) Generalized Arterio Sclerosis DUE TO Years (c) Isolated Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Isolated Myocardial Infarction			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/8/67 to 7/13/67 , that (I) (we) last saw the deceased alive on 7/13/67 , and that death occurred at 3:54 AM from causes and on the date stated above			
22a SIGNATURE John J. Curry		22b DATE SIGNED 7/13/67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS 10620 Georgia Ave. N.W.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7/15/67	23c NAME OF CEMETERY OR CREMATORY Maple Grove Cemetery	23d. LOCATION (City or Town) (County) (State) Kingwood W.Va.
24. FUNERAL DIRECTOR R.V. Murphy Funeral Home Arlington, Va.		25a. REC'D BY REGISTRAR DATE JUL 17 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 '67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09701		09706	
PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN TB <i>1823 Avenel Road</i>		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
3. NAME OF DECEASED (Type or print) <i>Julian Robert Carter</i>		4. DATE OF DEATH Month <i>7</i> Day <i>12</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-30-22</i>
9. AGE (In years last birthday) <i>44</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John R. Carter</i>		14. MOTHER'S MAIDEN NAME <i>Kate Francis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>232-30-8154</i>	
17. INFORMANT <i>REAR-FAMILY</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Gunshot wound, left</i> DUE TO (b) <i>Chest, with exsanguination</i> DUE TO (c) <i>chest, with exsanguination</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Deceased, depressed, shot & self in chest</i>	
20c. TIME OF INJURY Month Day Year <i>9:30 PM 7-12-67</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>Woods</i>	20f. (City or town) (County) (State) <i>Silver Spring Montgomery Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D.		22. DATE SIGNED <i>7-12-1967</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		Address (City or town) (County) (State) <i>Silver Spring Md</i>	
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>July 16, 1967</i>	23c. NAME OF CEMETERY OR CREMATOR <i>Draper Cemetery</i>	23d. LOCATION (City or town) (County) (State) <i>Draper North Carolina</i>
24. FUNERAL DIRECTOR <i>W. W. Chambers Co., Silver Spring Md</i>		25a. REC'D BY REGISTRAR <i>JUL 17 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09702

CERTIFICATE OF DEATH

09702

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
c. LENGTH OF STAY IN 1b. <u>4 days</u>		d. STREET ADDRESS <u>12516 Denley Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Bernard Wheeler Clark</u>		4 DATE OF DEATH <u>July 11 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-99 67</u> yrs
9 AGE (in years last birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Clark</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wheeler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-08-0753</u>	
17. INFORMANT <u>Washington Sanitarium</u>		Address <u>Takoma Park, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Cerebral & Cerebral</u> DUE TO (c) <u>Carcinoma of Palate & Nasopharynx</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/7</u> , 19 <u>67</u> , to <u>7/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/10</u> , 19 <u>67</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>R. Merrel Olsen</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. MERREL OLSEN, M.D.</u>		22d. ADDRESS <u>831 University Blvd, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JULY 13 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers</u>		ADDRESS <u>SILVER SPRING MD</u>	25a. REC'D BY REGISTRAR <u>JUL 14 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09703

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09708

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>-</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c LENGTH OF STAY IN 'b <u>16 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Asbury Methodist Home for aged</u>		d STREET ADDRESS <u>6 St. Martin's Rd</u>	
3 NAME OF DECEASED (Type or print) <u>ANNA May Cline</u>		4 DATE OF DEATH <u>July 8 1967</u>	
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 11, 1893</u> 9 AGE (In years last birthday) <u>74 yrs</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11 BIRTHPLACE (State or foreign country) <u>Penn.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Gilbert T. Israel</u>		14 MOTHER'S MAIDEN NAME <u>E. Virginia Keeton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO. <u>-</u>	
17 INFORMANT <u>Miss Shirley Biddison</u>		21162 Ontario Rd. NW Washington, D. C.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>Coronary Vascular Disease</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u>-</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>-</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> pm	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.		22. DATE SIGNED <u>July 8, 1967</u>	
EXAMINER'S NAME (Type) <u>John B. Bell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>-</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7/11/1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>Wm J. Duckner & Sons</u>		25 DEC'D BY REGISTRAR <u>JUL 11 1967</u> 25b REGISTRAR'S SIGNATURE <u>John B. Bell</u>	

CERTIFICATE OF DEATH

09704

09709

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c LENGTH OF STAY IN b <u>2 years</u> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10712 Gregory Street</u>		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d STREET ADDRESS <u>10712 Gregory Street</u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Grace Cobb</u>		4. DATE OF DEATH Month Day Year <u>July 12 19 67</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan 1, 1899</u>
9 AGE (In years last birthday) <u>68</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>(Unknown) Wood</u>	
14. MOTHER'S MAIDEN NAME <u>Bertie Plumley</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>No</u> <u>NONE</u>	
16 SOCIAL SECURITY NO <u>Yes</u>		17 INFORMANT <u>Albert B. Cobb</u> Address <u>10712 Gregory Street Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>5 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12 March, 19 65</u> to <u>12 July, 1967</u> , that (I) was last saw the deceased alive on <u>18 March 1967</u> , and that death occurred at <u>8 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Serach T. Kimble</u>		22b. DATE SIGNED <u>7-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Serach J. Kimble</u>		22d. ADDRESS <u>922 Pershing Drive, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 15, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24 FUNERAL DIRECTOR <u>Glen Carter, C. Kin C. Warner & Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

17 - cleared by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (detach) papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09705

09710

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>11340 Cherryhill Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>None</u> Middle <u>Cohn</u> Last		4 DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 B. DATE OF BIRTH <u>8-17-86</u>
9 AGE (In years last birthday) <u>80</u> yrs		10 IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> IF UNDER 24 HRS Hours <u>29</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Casper Gron s</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>088-16-7698</u>	
17 INFORMANT <u>Washington Sanitarium Takoma Park, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Consecutive heart failure</u> DUE TO <u>cardiac asthma</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Rheumatic fever</u> DUE TO <u>childhood</u>			INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-21</u> , 19 <u>67</u> , to <u>7-29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7-29</u> , 19 <u>67</u> , and that death occurred at <u>8:15 P.M.</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Walter E. Goozh MD</u>		22b DATE SIGNED <u>7/29/67</u>	
22c PHYSICIAN'S NAME (Type) <u>WALTER E. GOOZH MD</u>		22d ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>July 31, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Hyattsville, Pr. George, MD.</u>
24 FUNERAL DIRECTOR <u>Donald M. Stein Hebrew Memorial Funeral Home</u>		25a REC'D BY REGISTRAR <u>AUG 1 1967</u>	
ADDRESS <u>252 Carroll St. N.W. - Wash., D.C.</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09706

09711

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>FLORIDA</u> b. COUNTY <u>SEMINOLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>APOPKA</u>	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>3051 CECILIA DRIVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Holy Cross Hospital</u>		e. RESIDENCE ON A FARM <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3 NAME OF DECEASED (Type or print) First Middle Last <u>FRANK EDWARD COLE</u>		4 DATE OF DEATH Month Day Year <u>JULY 19 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-63</u>
9. AGE (in years lost birthday) <u>4</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>FLORIDA</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GORDON WILLIAM COLE</u>		14. MOTHER'S M maiden name <u>ETHYLE ROBBINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>GORDON W. COLE</u>		Address <u>(SAME AS ABOVE)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> DUE TO (b) <u>due to Asphyxiation due to</u> DUE TO (c) <u>Drowning</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I for Part II (item 1b)) <u>Deceased fell in pool in back yard and drowned.</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30 PM 7-19 1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Home</u>		20f. (City or town) <u>Apopka</u> (County) <u>Howard</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>7-20-1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Whiston</u> Address (Street and town and county)	
23a. BURIAL CREMATION <u>Burial</u>	23b. DATE THEREOF <u>July 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>	23d. LOCATION (City or town) (County) (State) <u>Winter Park, Florida</u>
24. FUNERAL DIRECTOR <u>James Staller</u> ADDRESS <u>4144 DC 354 Carroll ST NW</u>		25a. REC'D BY REGISTRAR <u>JUL 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

09707

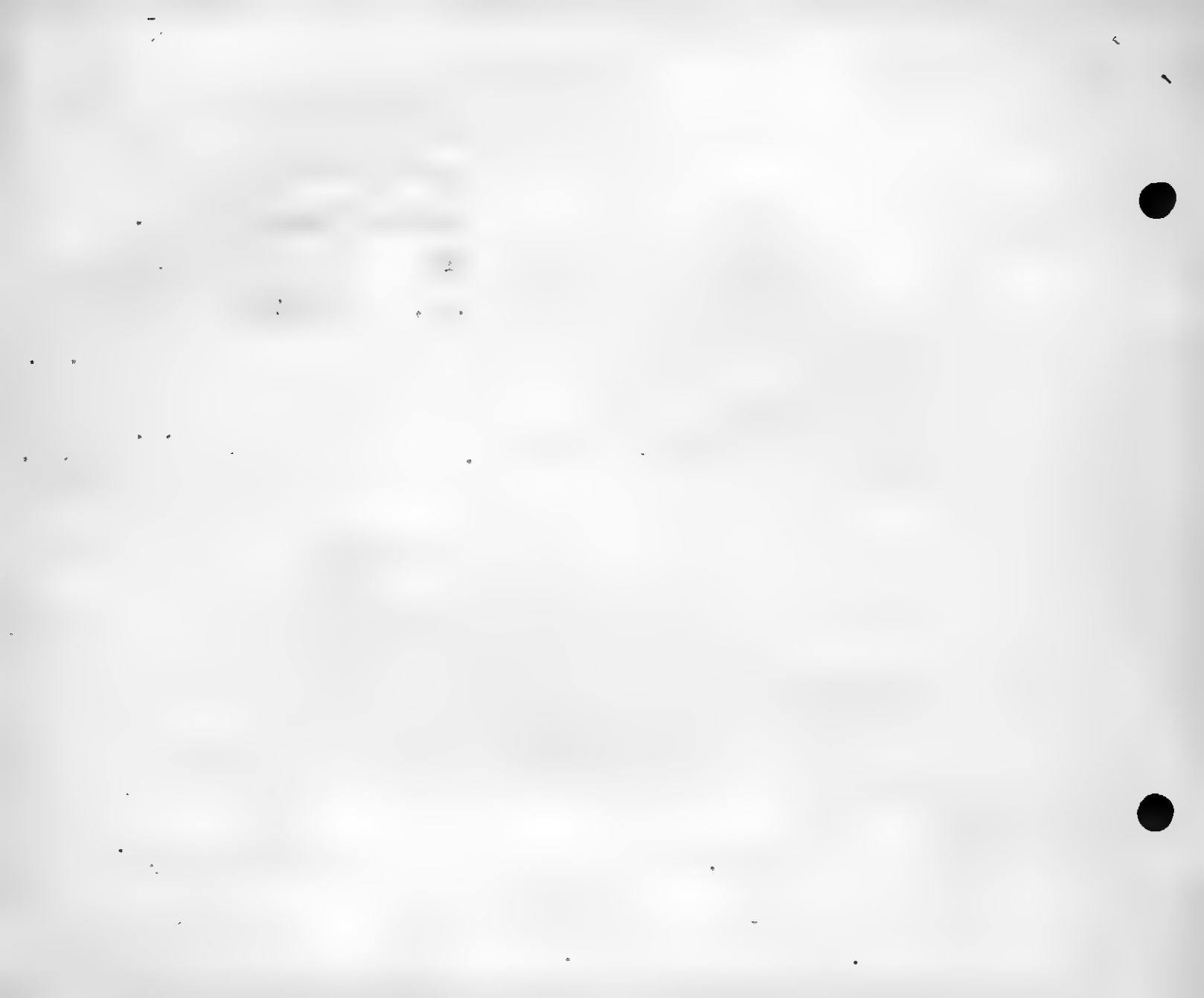
CERTIFICATE OF DEATH

1967

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
c. LENGTH OF STAY IN 1b 3 WEEKS		d. STREET ADDRESS Route 1, Stony Creek Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3709 Elby Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) HELEN LEE CONNELLY		4 DATE OF DEATH July 18, 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 7, 1898
9 AGE (In years birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ollie Downes		14. MOTHER'S MAIDEN NAME Julia Duley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 218-24-3397	
17. INFORMANT Daughter		Address P.O. Box 405 Mrs. Louise L. Richard- Glendale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Paul. infarction DUE TO (b) Carcinoma of M. breast DUE TO (c) Diabetes Mellitus & C.F.D. (ASCD)			INTERVAL BETWEEN ONSET AND DEATH 3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4/2/1954 to 7/18/1967 that (I) (we) last saw the deceased alive on 7/17/1967 , and that death occurred at 3:50 AM , from causes and on the date stated above.	
22a. SIGNATURE Stephen N. Jones		22b. DATE SIGNED 7/18/67	
22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES		22d. ADDRESS 809 Veirs Mill Rd. Rockville, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-21-67	
23c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		23d. LOCATION (City or town) (County) (State) Darnestown, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

713

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Montgomery.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda.</u>		c. LENGTH OF STAY IN TB <u>3 hr. 10 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Donald L. Cooper</u>		4 DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>M.</u>	6 COLOR OR RACE <u>Negro.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 9, 1943</u>
9 AGE (In years lost birthday) <u>24</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Ernest Cooper</u>	
14 MOTHER'S MAIDEN NAME <u>Dorothy Thomas</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17. INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Struck in chest in fight</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>kn</u> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Struck in chest in fight</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:15 PM</u> <u>7/21</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Side walk</u>		20f. (City or town) (County) (State) <u>Rockville Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John W. Ball</u> MD		22. DATE SIGNED <u>7/22/67</u>	
EXAMINER'S NAME (Type) <u>John W. Ball</u>		23a. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Md.</u>	
23b. DATE THEREOF <u>7/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	
23d. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23e. REC'D BY REGISTRAR DATE <u>JUL 27 1967</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

09709

CERTIFICATE OF DEATH

03714

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 35 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4319 River Road N. W., Apt. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Stephen Nicholas Cooper		4. DATE OF DEATH Month Day Year July 21 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 1921 9. AGE (In years lost birthday) yrs 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Federal Government	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Cooper		14. MOTHER'S MAIDEN NAME Anna Mulich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1942-1945		16. SOCIAL SECURITY NO Not available	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable septicemia DUE TO (b) Candidiasis - gastrointestinal tract DUE TO (c) Acute Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH Unknown 2 weeks 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 16, 1967 , to July 21, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 21, 1967 , and that death occurred at 4:45 M. , from causes and on the date stated above			
22a. SIGNATURE Thomas Clancy M.D.		P.M. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b. DATE SIGNED 22 July 1967	
22c. PHYSICIAN'S NAME (Type) Thomas Clancy, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 24, 67	23c. NAME OF CEMETERY OR CREMATORY St. Mary Magdalene Cem., Easton, Pennsylvania	23d. LOCAL ON (City or Town) (County) (State)
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS BETHESDA, MD.		25a. RECORD IN REGISTER JUL 25 1967 DATE for record Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03715

097:0

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> Minutes c LENGTH OF STAY IN 1b <u>Minutes</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hospital</u>		d STREET ADDRESS <u>10608 Sweetbrier Pkwy</u>	
3 NAME OF DECEASED (Type or print) <u>Charlotte Marie Copping</u>		4 DATE OF DEATH Month <u>7</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 7-12 55</u>
9 AGE (In years last birthday) yrs. <u>12</u>		10 IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11 BIRTHPLACE (State or foreign country) <u>Manila, Philippines</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13 FATHER'S NAME <u>Albert Brazee</u>		14 MOTHER'S MAIDEN NAME <u>Consuelo Palma</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT <u>Hus. Bennett Copping</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4301 Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>lost</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour <u>pm</u> 19 <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <u>July 10, 1967</u>		23a BIRTH, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b DATE THEREOF <u>July 13, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery, Arlington, Virginia</u>	
23d LOCALITY (City or town) (County) (State)		25a REC'D BY REGISTRAR <u>JUL 14 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c REGISTRAR'S SIGNATURE	

69711

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

69716

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Bronx NY. <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c LENGTH OF STAY IN 1b	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capital Heights W. HYATTSVILLE</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d STREET ADDRESS <u>@ 2807 Nicholson St. Hyattsville</u>	
3. NAME OF DECEASED (Type or print) <u>Frank James Corbett</u>		4 DATE OF DEATH <u>July 23 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/29/1887</u>
9 AGE (In years, last birthday) <u>80</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Transit operator</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Bronx NY.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>JAMES J. CORBETT</u>	
14. MOTHER'S MAIDEN NAME <u>MARY O'NEIL</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W.I.</u>	
16 SOCIAL SECURITY NO <u>578 10 6665A</u>		17 INFORMANT <u>IVAH V CORBETT,</u> Address <u>SAME AS #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Arrest</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Other: Sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pyelo Nephritis</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> to <u>7/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/22</u> 19 <u>67</u> , and that death occurred on <u>7/23</u> PM, from causes and on the date stated above			
22a SIGNATURE OF PHYSICIAN <u>E. STUART LYDANNE</u>		22b DATE SIGNED <u>7/23/67</u>	
22c PHYSICIAN'S NAME (Type) <u>E. STUART LYDANNE</u>		22d ADDRESS <u>3066 QUE ST. N.W. D.C.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>JULY 27, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM</u>	23d LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers Co Riverdale Md</u>		25a REC'D BY REGISTRAR DATE <u>JUL 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Young</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1643 E. Jefferson Street		d. STREET ADDRESS 1643 E. Jefferson Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EDWIN T. CORNELIUS		4. DATE OF DEATH July 20, 1967 Month July Day 20 Year 1967	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/24/87 9. AGE (In years last birthday) 80 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Samuel Cornelius		14. MOTHER'S MAIDEN NAME Delilah Lear	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 449-50-6236	
17 INFORMANT Lottie R. Cornelius-Item# 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) GRANULOCYTIC LEUKEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from JUNE, 1963 , to 7-20, 1967 , that (I) (we) last saw the deceased alive on 7-20, 1967 , and that death occurred at 2:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE W. G. Hall		22b. DATE SIGNED 7-20-67	
22c. PHYSICIAN'S NAME (Type) W. G. Hall		22d. ADDRESS 615 W. Montg. Ave., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/24/67	23c. NAME OF CEMETERY OR CREMATORY Parklawn	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24 FUNERAL DIRECTOR Lyson Wheeler		25a. REC'D BY REGISTRAR JUL 25 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 1331 Rockville Pike Rockville, Md.	



Clearance with Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09713

CERTIFICATE OF DEATH

09713

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAXMA PARK</u> c. LENGTH OF STAY IN 1b <u>1 hour</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN & HOSPITAL</u>		d. STREET ADDRESS <u>7705 24th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Gibbons</u> Middle <u>Crabtree</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 18 1913</u>
9. AGE (In years last birthday) <u>53</u> yrs		10. IF UNDER 1 YEAR Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Peoples Drug Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Walker Crabtree</u>		14. MOTHER'S MAIDEN NAME <u>Emmalynne Murphree</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>None</u>		16. SOCIAL SECURITY NO <u>415-12-2304</u>	
17. INFORMANT <u>Sara Crabtree</u> Address <u>7705 24th Avenue Adelphi, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO (b) <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>May 17 1967</u> to <u>July 21 1967</u> , that (I) (we) last saw the deceased alive on <u>June 17 1967</u> , and that death occurred at <u>5:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Seruch T. Kimble</u>		22b. DATE SIGNED <u>7-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u>		22d. ADDRESS <u>927 Pershing Dr., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Prince Georges Co. Md.</u>
24. F. N. DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		DATE <u>JUL 25 1967</u>	

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN lb <u>15 hrs</u>		d. STREET ADDRESS <u>1703 East-West Highway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louise C Cressler</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1877</u>
9. AGE (In years last birthday) <u>89 yrs</u>		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Inbelder</u>		14. MOTHER'S MAIDEN NAME <u>Wilhelmina Eickoff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO <u>213-50-4911</u>	
17. INFORMANT <u>Mrs. Donald Staley</u>		Address <u>1703 East-West Hwy. Hospital Chart, Washington Sanitarium</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>B. candida pneumonia</u> DUE TO (b) <u>3 days</u> DUE TO (c) <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>63</u> , to <u>7-14</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>67</u> , and that death occurred at <u>11:2</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>Senuch T. Kimble</u>		22b. DATE SIGNED <u>7-16-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Senuch T. Kimble</u>		22d. ADDRESS <u>927 Pershing Dr., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 18, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>	
Address <u>434 Georgia Avenue</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Funeral Home <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>			

TO HOSPITAL: A **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed **24 hours after** death. Page 4 **be retained by the hospital or attending physician**.
TO **FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0572

1. PLACE OF DEATH e. COUNTY <u>Mont. Co.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaflorida 7 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>305 N. Adams St. Apt 4</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Crider</u>		4. DATE OF DEATH <u>July 23 1967</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/23/67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fred Crider</u>		14. MOTHER'S MAIDEN NAME <u>June Crider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mother's Chart.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neonatal atelectasis</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1967</u> to <u>July 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 23, 1967</u> , and that death occurred at <u>P.M.</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>7/23/67</u>	
22a. SIGNATURE <u>Edward J. Zwili</u>		22c. PHYSICIAN'S NAME (Type) <u></u>	
22d. ADDRESS <u></u>		22e. REC'D BY REGISTRAR <u></u>	
23a. BURIAL REMOVAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> DATE THEREOF <u>7/24/67</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>	
23c. LOCATION (City, town or county) <u>Bethesda - Montgomery - Md.</u>		23d. REGISTRAR'S SIGNATURE <u>Charles Juage</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Amelia C. Carter - Administrator</u>		25. DATE <u>JUL 28 1967</u>	

00716

CERTIFICATE OF DEATH

00721

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2 USUAL RESIDENCE (Where deceased lived, if instit. an Residence before adm ssion) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 844 Jefferson St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Thomas First Middle Last Walter Crockett		4 DATE OF DEATH Month Day Year 7 27 19 67	
5 SEX male	6 COLOR OR RACE colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 3, 1899
9 AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) South Carolina	
12 CIT ZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Crockett	
14. MOTHER'S MAIDEN NAME Louise Galmon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 578-05-6276		17. INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of cecum 1537 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Transverse Colon DUE TO (c)			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 25, 1967 , to July 27, 1967 that (I) (we) last saw the deceased alive on July 25, 1967 , and that death occurred at 7:30 A.M. , from causes and on the date stated above			
22a. SIGNATURE Blanche G. Bendler		22b. DATE SIGNED 7-28-67	
22c. PHYSICIAN'S NAME (Type) Blanche G. Bendler		22d. ADDRESS 10820 Georgia Avenue Wheaton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-1-67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (City or Town) (County) (State) Landover, P. G., Md.
24 FUNERAL DIRECTOR Hall Bros. Funeral Home, 621 Fla., Ave., N.W. Washington, D. C.		25a. REC'D BY REGISTRAR DATE AUG 2 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05722

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jakoma Park		c. LENGTH OF STAY IN b. 3 years		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 616 Elm Street						d. STREET ADDRESS 616-Elm Street			
3. NAME OF DECEASED (Type or print) First Mary Middle E Last Curtis						4. DATE OF DEATH Month July Day 4 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1894		9. AGE (In years last birthday) yrs. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Germantown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Wallace Hughes						14. MOTHER'S MAIDEN NAME Martha Biggs			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 577-05-8979		17. INFORMANT Harry J. Curtis Address 616 Elm Street, Jakoma Park, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular fibrillation (acute) 4331 DUE TO (b) Arteriosclerotic cardiovascular disease 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from July , 19 63 , to July 4 , 19 67 that (I) (we) last saw the deceased alive on July 3 , 19 67 , and that death occurred at 9 P M, from causes and on the date stated above.									
22a. SIGNATURE John D. Griswold						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4 July 1967	
22c. PHYSICIAN'S NAME (Type) John D. Griswold M.D.						22d. ADDRESS 4830 V St NW DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Darnestown Presbyterian Cemetery		23d. LOCATION (City or Town) (County) (State) Darnestown, Maryland			
24. FUNERAL DIRECTOR C. Glen Carter Address 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.						25a. REC'D BY REGISTRAR DATE JUL 7 1967		25b. REGISTRAR'S SIGNATURE Charles George	

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>1 mo.</u>		d. STREET ADDRESS <u>1301 Kalmia Road N. W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>M.</u> Last <u>Daffer</u>		4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/81</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>67</u> Min	IF UNDER 24 HRS Hours <u>67</u> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Patrick Leary</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Calnan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Nell Leary</u>		Address <u>4550 Conn. Ave. N.W. Wash DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Generalized Arteriosclerosis</u> DUE TO <u>5 days</u> (b) <u>1 year</u> (c) <u>5 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO (a) TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/20/67</u> to <u>7/3/67</u> , that (I) (we) last saw the deceased alive on <u>7/3/67</u> , and that death occurred at <u>7/3/67</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>7/3/67</u>	22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-6-67</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Mt. Olivet</u>
23d. LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>		24. FUNERAL DIRECTOR <u>James J. Collins</u>	ADDRESS <u>F.J.C. 1421 14th St. N.W. Wash DC</u>
25a. REC'D BY REGISTRAR <u>JUL 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09719

CERTIFICATE OF DEATH

09724

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN IB <u>3 Weeks</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home Wheaton, Md.</u>		d. STREET ADDRESS <u>11225 Newport Mill Rd.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Nolia Davis</u>		4 DATE OF DEATH Month Day Year <u>July 19, 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Caus.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/12/1903</u>
9 AGE (In years last birthday) yrs <u>64</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b KIND OF BUSINESS OR INDUSTRY <u></u>		11 BIRTHPLACE (County & State, or foreign country) <u>Hazleton, Pennsylvania</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>James Jones</u>	
14 MOTHER'S MAIDEN NAME <u>(Unknown) Edwards</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>553-52-7115</u>		17 INFORMANT <u>Son</u> <u>11225 Newport Mill</u> <u>George A. Davis -Kensington, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>5 years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/4</u>, 19<u>67</u>, to <u>7/19</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>7/19</u>, 19<u>67</u>, and that death occurred at <u>1 A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Richard H. Pallen</u>		22b. DATE SIGNED <u>7/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. PALLAN</u>		22d. ADDRESS <u>10403 CONNECTICUT AVE, KENSINGTON, MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7-22-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Beallsville, Maryland</u>	
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>JUL 24 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c REGISTRAR'S SIGNATURE <u></u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

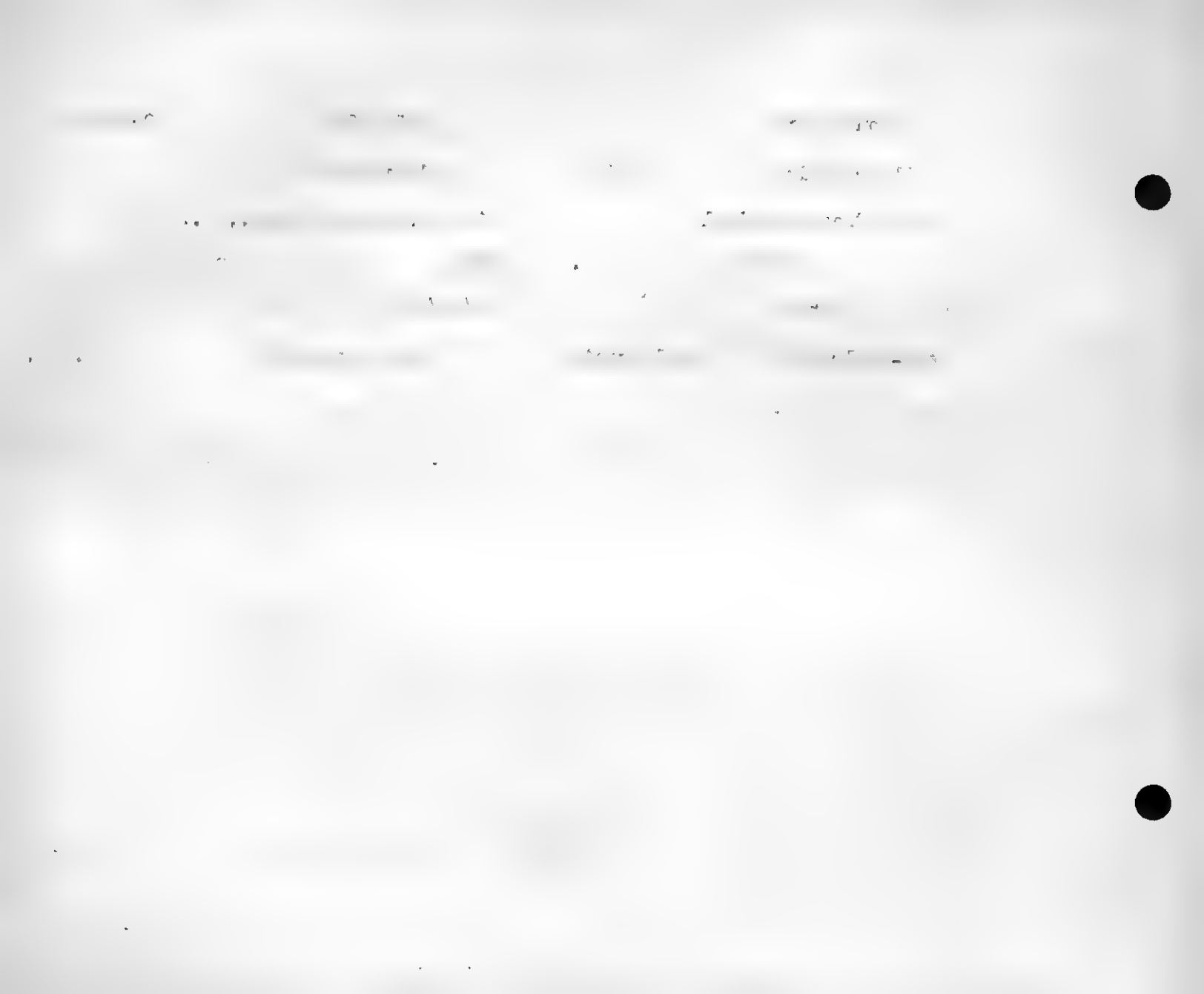
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 392
9-8-67 ams

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00725

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN b. 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 1111 University Blvd., W., #806	
3. NAME OF DECEASED (Type or print) WILLIAM J. DAVIS		4. DATE OF DEATH Month July Day 24 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/1900
9. AGE (In years of birthday) yrs 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed Broker	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas William Davis		14. MOTHER'S MAIDEN NAME Melissa Womack	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 579-05-9987	
17. INFORMANT Mabel B. Davis		Address 1111 University Blvd. W Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 4301 IMMEDIATE CAUSE (a) Acute coronary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic heart disease DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Heap		22. DATE SIGNED 7/24/1967	
EXAMINER'S NAME (Type) BELDEN R. HEAP MD		DEPUTY MEDICAL EXAMINER Address, Street, City, County, State	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 27, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or town) (County) (State) Prince Georges Co., Md.
24. FUNERAL DIRECTOR John B. Thomas		25. REC'D BY REGISTRAR JUL 31 1967	
Address 434 Georgia Avenue		REGISTRAR'S SIGNATURE John B. Thomas	
Warner E. Humphrey, Inc. Silver Spring, Maryland			



CERTIFICATE OF DEATH

09726

00721

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>30 years</i>	2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1314 Cresthaven Drive</i>					d. STREET ADDRESS <i>1314 Cresthaven Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>GRACE</i>		First <i>Elizabeth</i>		Middle <i>DILL</i>		Last <i>DILL</i>	
4. DATE OF DEATH Month <i>July</i>		Day <i>26</i>		Year <i>19 67</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 15, 1899</i>	9. AGE (In years lost birthday) <i>68 yrs</i>	10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Hampton, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John M. Walker</i>				14. MOTHER'S MAIDEN NAME <i>Susan Jane Bulfinch</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>214-05-2561</i>		17. INFORMANT <i>Herman M. Dill</i> Address <i>1314 Cresthaven Drive Silver Spring, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <i>1538</i> IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i> DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>over one year</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 29</i> , 19 <i>67</i> , to <i>July 26</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>7/26 1967</i> , and that death occurred at <i>7:35 AM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>Norman H. Rubenstein</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7/26/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Norman H. Rubenstein, M.D.</i>				22d. ADDRESS <i>11161 New Hampshire Ave. S. S. Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 29, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas</i> <i>Warner E. Humphrey, Inc.</i>				ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>JUL 31 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
25M 1/67

09722

CERTIFICATE OF DEATH

89727

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>68 Days</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Queens</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jamaica</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Christopher Dillane</u>				4. DATE OF DEATH Month Day Year <u>July 30 19 67</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>8 December 1935</u>		9. AGE (In years last birthday) <u>31 yrs</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Protection</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Thomas Dillane</u>			
14. MOTHER'S MAIDEN NAME <u>Catherine McNamara</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1959 - 59</u>			
16. SOCIAL SECURITY NO <u>132-32-2424</u>				17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Trophoblastic Carcinoma Metastatic to Lungs</u> DUE TO (c) <u>Primary site - left testis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>3 months</u> <u>Unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>23 May</u> , 19 <u>67</u> , to <u>30 July</u> , 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>30 July</u> , 19 <u>67</u> , and that death occurred at <u>12:25 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>William E. Bridson</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>30 July 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>William E. Bridson, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/31/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>QUEENS, NEW YORK CITY, NY</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>HYSONG'S FUNERAL HOME</u>		ADDRESS <u>WASH.D.C.</u>		25a. REC'D BY REGISTRAR <u>AUG 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00728

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00728

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Res dence before adm ssion) a. STATE MD. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 1/2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSP TAL OR INSTITUTION (If not a hospital give street address) HOLY CROSS HOSPITAL				d. STREET ADDRESS 4 PARKSIDE RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle ASA Last DILLON				4. DATE OF DEATH Month 7 Day 31 Year 19 67			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/19/01		9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 6 Days 11 Hours 31 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer, U. S. Govt.		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Mc Clouth, Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George F. Dillon				14. MOTHER'S MAIDEN NAME Emma Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-44-8337		17. INFORMANT Alethea B. Dillon Address 4 Parkside Road Silver Spring, Maryland			
18. CAUSE OF DEATH (Enter only one cause per Part I. Death was caused by: IMMEDIATE CAUSE (a) Bilateral Massive Pulmonary Embolus. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pulmonary Embolus. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca of Prostate with Retroperitoneal Metastasis							
20a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Read M.D.				22. DATE SIGNED July 31, 1967			
EXAMINER'S NAME (Type) BELDEN R. READ, M.D.				Address (Street, City, Town, or County)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Coleville Methodist Cem.		23d. LOCATION (City or Town) (County) (State) Coleville, Maryland	
24. FUNERAL DIRECTOR C. Glen Carter Address 8434 Georgia Avenue				25a. REC'D BY REGISTRAR AUG 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
Printer E. Humphrey, Inc. Silver Spring, Maryland							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Clear Dr Medical Examiner 6.6.6

09724

CERTIFICATE OF DEATH

09729

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 121	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 3608 Randolph Rd	
3 NAME OF DECEASED (Type or print) Benjamin-Franklin- Dixon		4. DATE OF DEATH 7 - 22 19 67	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-17-05
9 AGE (In years last birthday) 62 yrs.		10 IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Davidsonville, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Eldridge Edwin Dixon		14 MOTHER'S MAIDEN NAME Frances Phipps	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 577-22-0730	
17. INFORMANT Mrs. Amelia Dixon		Address 3608 Randolph Rd Silver Spring Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO (b) CORONARY THROMBOSIS DUE TO (c) ATHEROSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 2 Hours + HOURS + ? YEARS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 15 , 19 67 , to July 22 , 19 67 , that (I) (we) lost saw the deceased alive on July 15 , 19 67 , and that death occurred at 11 PM , from causes and on the date stated above			
22a SIGNATURE Hugo G. Graziani, M.D. Dr. John Cuby, M.D.		22b DATE SIGNED 7/22/67	
22c PHYSICIAN'S NAME (Type) HUGO G. GRAZIANI, M.D.		22d ADDRESS 10101 Georgia Ave., S.S., Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF July 26 1967	23c NAME OF CEMETERY OR CREMATORY Rockville	23d LOCATION (City or town) (County) (State) Rockville Md
24. FUNERAL DIRECTOR John P. [Signature]		25a REC'D BY REGISTRAR JUL 25 1967	
25b REGISTRAR'S SIGNATURE [Signature]		25c REGISTRAR'S NAME John P. [Signature]	

00725

CERTIFICATE OF DEATH

00760

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
69
Cleared to Burial - 7:15 P.M.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 3709 Elby Street	
3. NAME OF DECEASED (Type or print) First Burgess Middle E Last Dodson		4. DATE OF DEATH Month July Day 15 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-3-1904
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 19 Min 67	
10a. US. JAL OCCUPATION (Give kind of work done during most of working life even if retired) Body & Fender		10b. KIND OF BUSINESS OR INDUSTRY Auto	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CIT. ZEN. OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther Dodson		14. MOTHER'S MAIDEN NAME Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO 579-07-9886	
17. INFORMANT Son		2006 Rockland Ave. Upton L. Dodson - Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost YEARS DUE TO (b) (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/14 , 19 67 , to 7/15 , 19 67 , that (I) (we) last saw the deceased alive on 7/15 , 19 67 , and that death occurred at 5:00 M., from causes and on the date stated above.			
22a. SIGNATURE Richard H. Pollen		22b. DATE SIGNED 7/16/67	
22c. PHYSICIAN'S NAME (Type) RICHARD H. POLLEN MD		22d. ADDRESS 10400 CONNECTICUT AVE, KENSINGTON MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-18-67	
23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City or Town) (County) (State) Beallsville, Maryland	
24. FUNERAL DIRECTOR Robert A. Pennington		25a. REC'D BY REG STRAR JUL 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



09726

CERTIFICATE OF DEATH

09731

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓ a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>17 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>505-B Charles Street</u>	
3 NAME OF DECEASED (Type or print) <u>Joseph August Dold</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 March 1920</u>
9. AGE (In years lost birthday) <u>47</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboratory Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Dold</u>		14. MOTHER'S MAIDEN NAME <u>Emily Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1942-1945</u>		16. SOCIAL SECURITY NO <u>203-09-1999</u>	
17. INFORMANT <u>The Medical Records</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Status Epilepticus</u> DUE TO (c) <u>Craniopharyngioma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>38 hours</u> <u>5 years</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 3</u> , 19 <u>67</u> , to <u>July 20</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 20</u> , 19 <u>67</u> , and that death occurred at <u>8:35</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Ratcheson</u>		22b. DATE SIGNED <u>20 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Ratcheson, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL REMOVAL</u>	23b. DATE THEREOF <u>22 JULY 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EASTON PA.</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>CRINALI FUNERAL HOME INC 7400 GEORGIA AVE. N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 24 1967</u>	
ADDRESS <u>20012</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

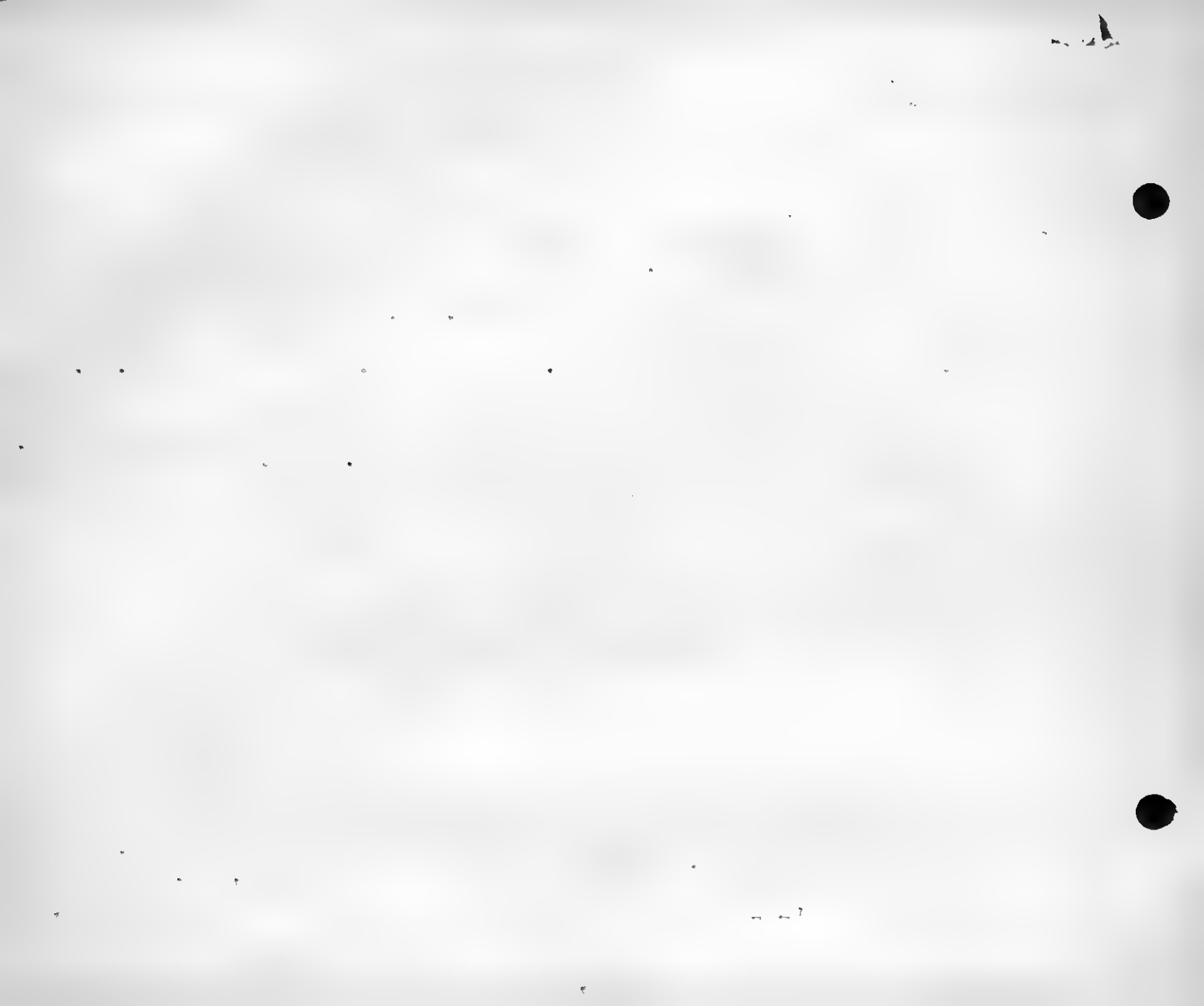
09721

05732

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 16 YRS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2608 Weisman Road		2 USUAL RESIDENCE (Where deceased lived, if institution Reside before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. STREET ADDRESS 2608 Weisman Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First FRANCIS Middle J. Last DUNN		4 DATE OF DEATH Month July Day 29 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 26, 1902
9. AGE (In years last birthday) 65 yrs		IF UNDER 1 YEAR Months 65 Days 65	IF UNDER 24 HRS Hours 65 Min. 65
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Sales Manager -Wheaton Dorr Co.		10b. KIND OF BUSINESS OR INDUSTRY Penna.	12 CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Peter Dunn		14. MOTHER'S MAIDEN NAME Frances McDermott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 171-01-9081A	
17 INFORMANT Wife Address Same as Item 2. Elizabeth J. Dunn.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection DUE TO Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Car. of Lung (b) Car. of Lung (c) Car. of Lung		INTERVAL BETWEEN ONSET AND DEATH 120 d	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aneurysm of aorta		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/1/1967 to 7/30/1967 , that (I) (we) lost saw the deceased alive on 7/28/1967 , and that death occurred at 6:22 P.M. from causes and on the date stated above.			
22a. SIGNATURE Stephen N. Jones		22b. DATE SIGNED 7/31/67	
22c. PHYSICIAN'S NAME (Type) STEPHEN N. JONES		22d. ADDRESS 809 Viers Mill Rd. Rockville, Md.	
23a. BURIAL CREMATION, REMOVAL (Type) Burial	23b. DATE THEREOF 8-1-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or town) (County) (State) Silver Spring Mont. Md
24. FUNERAL DIRECTOR Robert A Pumphrey ADDRESS 7557 Wisconsin Ave Bethesda, Md		25a. REC'D BY REGISTRAR DATE AUG 3 1967	25b. REGISTRAR'S SIGNATURE Charles J. Jones

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CERTIFICATE OF DEATH

9733

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) District Of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write full name of nearest town) Bethesda		c. LENGTH OF STAY IN 1b 12 Mos 3 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Charles (NMN) DWYER Middle Last		4. DATE OF DEATH Month 7 Day 31 Year 67	
5 SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23. 1906
9. AGE (In years last birthday) yrs 60		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Military	
11. BIRTHPLACE (County & State, or foreign country) Crab Orchard, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward L. DWYER		14. MOTHER'S MAIDEN NAME Nora TRAVELSTEAD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1926 to 1957		16. SOCIAL SECURITY NO. 299-50-47	
17. INFORMANT Isabel M. Dwyer		Address 4361 Nichols Ave S.W. WDC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Arteriolosclerotic Cerebral vascular disease severe with intracerebral vascular aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } 2. Squamous cell carcinoma of larynx post operative (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from * 28 July, 1966 to 31 July, 1967 , that (I) (we) lost saw the deceased alive on 31 July 1967 , and that death occurred at 7:41 PM , from causes on and on the date stated above.			
22a. SIGNATURE <i>R. J. Cavanagh</i>		22b. DATE SIGNED AUG. 1 1967	
22c. PHYSICIAN'S NAME (Type) R. J. CAVANAGH		22d. ADDRESS Naval Hospital, Bethesda	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8.4.1967	23c. NAME OF CEMETERY OR CREMATORY Arlington, National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR Lee Funeral		ADDRESS Home 4th & Massachusetts, N.E.	25a. REC'D BY REGISTRAR AUG 4 1967
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b STATE <u>Maryland</u> c COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>4809 Leland Street</u>	
3 NAME OF DECEASED (Type or print) <u>Robert Samuel Eastham</u>		4 DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 12, 1908</u>
9a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Dealer</u>		9b AGE in years (last birthday) <u>58</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Dealer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Self-employed - Bethesda, Md.</u>	
11 BIRTHPLACE (State or foreign country) <u>Bethesda, Md.</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>George E. Eastham</u>		14 MOTHER'S MAIDEN NAME <u>Virginia E. Riser</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16 SOCIAL SECURITY NO <u>21732-5450</u>	
17 INFORMANT <u>Mr. Robert Eastham, Jr. (Son)</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u>	
(b) <u>Cardio Vascular Disease -</u>		years <u>4</u>	
(c) <u>last</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work hat White <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>7/16/67</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Montgomery City, Md.</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7-19-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Prince Georges Co. Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Cawler's Sons, Inc.</u>		25a REC'D BY REGISTRAR <u>JUL 20 1967</u>	
Address <u>5130 Wisconsin Ave. N.W. Wash. DC.</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) c. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>20 days</u>		d. STREET ADDRESS <u>510 Azalea Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earl E</u> Middle <u>E</u> Last <u>Edes</u>		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/1892</u>
9. AGE (In years, last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Schools</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Winn Co. Wis</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Augustus Edes</u>		14. MOTHER'S MAIDEN NAME <u>Maria Cunningham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>397-03-9012</u>	
17. INFORMANT <u>Judith Edes</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>few weeks</u> <u>10-15 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus & Hypertension</u>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1967, to <u>16 July</u> , 1967, that (I) (we) last saw the deceased alive on <u>16 July</u> , 1967, and that death occurred at <u>4:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>W. Murphy</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>W. MURPHY</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/19/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>JUL 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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00731

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00736

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. STREET ADDRESS <u>8109 Grove St.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph (nmn) Embree</u>		4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/44</u>
9. AGE (In years last birthday) <u>23</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air conditioning engr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air conditioning</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>William Lewis Embree</u>		14. MOTHER'S MAIDEN NAME <u>Jemima Josephine Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>218-24-6295</u>	
17. INFORMANT <u>Violet Embree</u>		Address <u>8109 Grove Street Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA INVOLVING</u>			
DUE TO (b) <u>RIGHT LUNG & PLEURA</u>			
DUE TO (c) <u>PRIMARY SITE UNKNOWN</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/17</u> , 19 <u>67</u> to <u>7/21</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/21</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>David Colden</u>		22b. DATE SIGNED <u>7/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID COLDEN</u>		22d. ADDRESS <u>10620 Fagan Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 25, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John E. Thomas</u>		25a. REC'D BY REGISTRAR <u>JUL 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09732

Item #10 Film #35-149777 Ph

CERTIFICATE OF DEATH

09727

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>2 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hospital</i>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>8211 Queen Annes Drive</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>Ethel Dorothy Estep</i>		4. DATE OF DEATH Month Day Year <i>July 25 1967</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 25, 1906</i> 9. AGE (In years last birthday) yrs. <i>60</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Telephone operator</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	
11 BIRTHPLACE (County & State, or foreign country) <i>Mass.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles H. Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Phillips</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-01-2837</i>	
17. INFORMANT <i>Lewis Estep</i>		Address <i>8211 Queen Annes Drive Silver Spring, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <i>Myocardial Infarction</i> (c) <i>2 days</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerosis Generalized</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 5, 1964</i> to <i>July 25, 1967</i> that (I) (we) last saw the deceased alive on <i>July 15, 1967</i> and that death occurred on <i>July 25, 1967</i> at <i>4:45 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>John J. Curry</i>		22b. DATE SIGNED <i>7/25/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>John J. Curry</i>		22d. ADDRESS <i>10620 Georgia Ave Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>July 28, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>DATE JUL 31 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			

09733

CERTIFICATE OF DEATH

00738

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN TB <u>15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1804 BELVEDERE BLVD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norma W FARLEY</u>		4. DATE OF DEATH Month Day Year <u>7 6 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/19/15</u> 9. AGE (In years lost birthday) <u>51</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHERK -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRED T. WATSON SR.</u>		14. MOTHER'S MARDEN NAME <u>EMILY A. GLADMON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Edward F. Farley Jr</u> Address <u>SEE # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction right temporal lobe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombotic occlusion of: right vertebral artery</u> DUE TO (c) <u>right subclavian artery</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status post right subclavian innominate endarterectomy</u>			9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MAY, 1965</u> , to <u>7-6, 1967</u> , that (I) (we) last saw the deceased alive on <u>7-6, 1967</u> , and that death occurred at <u>11:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Francis Mayle, M.D.</u>		22b. DATE SIGNED <u>7/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis Mayle, M.D.</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Southland MD</u>
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Silver Spring MD</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

CERTIFICATE OF DEATH

09739

09734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before adm ssion) a. STATE <u>District of Columbia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>			c. LENGTH OF STAY IN lb <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Naval Hospital</u>				d. STREET ADDRESS <u>5169 Watson Street, N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Morrow</u> Last <u>Fechteler</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1896</u>	9. AGE (n years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>67</u> Min		
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Navy - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>San Rafael, California</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustus Fechteler</u>				14. MOTHER'S MAIDEN NAME <u>Maud Morrow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1912-1956</u>		16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>N.W., Washington</u> Address <u>D. C.</u> <u>Mrs. Goldye S. Fechteler, 5169 Watson Street</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting aortic aneurysm</u> <u>451X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>July 4</u> , 19 <u>67</u> , to <u>July 4</u> , 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>July 4</u> , 19 <u>67</u> , and that death occurred at <u>6:45 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>William R. Hix</u>				22b. DATE SIGNED <u>5 July 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>William R. Hix, M. D.</u>				22d. ADDRESS <u>Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>7-7-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler & Sons</u> ADDRESS <u>5130 Wisconsin Ave., N.W. Washington, D. C.</u>				25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00735

CERTIFICATE OF DEATH

05740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>6 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>12000 Rockledge Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Elizabeth</u> Last <u>Wright</u>		4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/1867</u>
9. AGE (In years last birthday) <u>100</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wright</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clarence Swann</u>		Address <u>260N. 11st. Neward N.J.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>400</u> DUE TO (b) <u>ASH</u> DUE TO (c) <u>24 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>24 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> , 19 <u>67</u> to <u>7/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> , 19 <u>67</u> , and that death occurred at <u>7M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>[Date]</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Name]</u>		22d. ADDRESS <u>[Address]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/7/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Comt.</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tinkner & Son</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>JUL 7 1967</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be certified with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MONTGOMERY STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>									
c. LENGTH OF STAY IN 1b <u>3 years</u>					d. STREET ADDRESS <u>1601 Bristow St</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1601 Bristow St</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>JEANNETTE G.</u> Middle <u>Fennell</u> Last <u>Fennell</u>					4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1967</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 11, 1926</u>		9. AGE (In years last birthday) <u>41</u> yrs						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AW.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
13. FATHER'S NAME <u>Guy A. GIFFER</u>					14. MOTHER'S MAIDEN NAME <u>FRANCES HARR</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT <u>FRANK Fennell</u> Address <u># 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, Breast metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from <u>8/66</u> 19 <u>66</u> to <u>7/29/67</u> 19 <u>67</u> , that (I) <u>last</u> saw the deceased alive on <u>7/27/67</u> 19 <u>67</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.														
22a. SIGNATURE <u>Henry C. Scruggs MD</u>					22b. DATE SIGNED <u>7/29/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS MD</u>					22d. ADDRESS <u>5413 Cedar Lane Bethesda, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					23b. DATE THEREOF <u>Aug 1, 1967</u>					23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>				
23d. LOCATION (City, town, or county) (State) <u>Wheaton, Ind</u>														
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Tattarull</u> ADDRESS <u>3603 14th St NW Wash. D.C.</u>					25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and return them to the State Dept. of Health prior to burial, cremation, or removal, and if they went, within 72 hours after death.

VR A15 (4)
25M 1/67

<div style="display: flex; justify-content: space-between;"> 09734 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 09742 </div>															
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>--- DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>						d. STREET ADDRESS <u>Box 97, 26008 Ridge Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <u>Carroll K. Fetzer</u>						4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1967</u>									
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>5/9/96</u>		9 AGE (n years last b rthday) yrs <u>71</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>			
10a USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b KIND OF BUSINESS OR IND. STRY <u>Naval Gun Factory</u>		11. BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>				12 CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13 FATHER'S NAME <u>William Fetzer</u>						14. MOTHER'S MAIDEN NAME <u>Minnie Koser</u>									
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W.I</u>				16. SOCIAL SECURITY NO <u>579-09-7977</u>		17 INFORMANT Address <u>Hospital Records, Olney, Maryland</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Rupture - abdominal aneurysm</u> DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>July 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 19, 1967</u> , and that death occurred at <u>7:05 PM</u> , from causes and on the date stated above.															
22a SIGNATURE <u>Frederick Noonan</u> M.D.						ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>7-21-67</u>							
22c PHYSICIAN'S NAME (Type) <u>Frederick Noonan</u>						22d ADDRESS <u>Olney, Maryland</u>									
23a BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				23b DATE THEREOF <u>July 23, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>				23d LOCATION (City or Town) (County) (State) <u>Damascus, Md.</u>					
24 FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>						25a REC'D BY REGISTRAR DATE <u>JUL 25 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>							

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mont. County Gen. Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> d. STREET ADDRESS <u>8950 Gue Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bennett</u> First <u>F</u> Middle <u>F</u> Last <u>Fishpaw</u>		4. DATE OF DEATH <u>July 1</u> Month <u>July</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Md.</u>	
13. FATHER'S NAME <u>Malcolm Fishpaw</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Parks</u>	
16. SOCIAL SECURITY NO. <u>W.W. # 2 218-05-6111</u>		17. INFORMANT <u>Mrs Cathryne Fishpaw, Item 2</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Acute Myocardial Dis.</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-7 days</u> <u>3 days</u> <u>4 yrs.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>-</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>		22. DATE SIGNED <u>July 1, 1967</u>	
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 4, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>		23d. LOCATION (City, town or county) (State) <u>Damascus, Md.</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth,</u>		25a. REC'D BY REGISTRAR <u>JUL 6 1967</u>	
ADDRESS <u>Damascus, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

09739

69744

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY IN TB <u>62 days</u>		d. STREET ADDRESS <u>104 Primrose St. Room 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Martha Florence</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-03</u>
9 AGE (In years last birthday) <u>64</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles Clark</u>		14 MOTHER'S MAIDEN NAME <u>Florence Conover</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>none</u>		16 SOCIAL SECURITY NO. <u>213-38-3605</u>	
17 INFORMANT <u>Hospital Records</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute heart failure</u> DUE TO (b) <u>CVA</u> DUE TO (c) <u>arteritis</u>	
19 INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>		20 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastric Ulcer</u> <u>Rheumatoid Arthritis</u>	
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
21c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>6-30</u>	21d INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	21e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	21f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>67</u> , to <u>7-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-30</u> , 19 <u>67</u> , and that death occurred at <u>5⁰⁰</u> AM, from causes and on the date stated above			
22a SIGNATURE <u>R. H. Sandstrom MD</u>		22b DATE SIGNED <u>7-1-67</u>	
22c PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom MD</u>		22d ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24 FUNERAL DIRECTOR <u>The S. H. Hines Co 2901-14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>JUL 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

09715

29740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>				d. STREET ADDRESS <u>7906 West park Dr.</u>			
3 NAME OF DECEASED (Type or print) First <u>Svend</u> Middle <u>E</u> Last <u>Frederiksen</u>				4 DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-06</u>		9. AGE (In years last birthday) <u>60</u> yrs		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ESKIMOLOGIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DENMARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>OLSEN FREDERIKSON</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>WM. A. HILLMAN, SON*IN*LAW</u> Address <u>Takoma Park, Md. 38 Columbia Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u> DUE TO (b) <u>Thrombophlebitis</u> DUE TO (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>67</u> , to <u>7-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-20</u> , 19 <u>67</u> , and that death occurred at <u>7:50</u> P.M., from causes and on the date stated above							
22a. SIGNATURE <u>R. Longoria, M.D.</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>R. Longoria, M.D.</u>	
22d. ADDRESS <u>8402 Tinton St, Silver Sp. Md.</u>				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Williams</u>		23d. LOCATION (City or Town) (County) (State) <u>Ft. Royal Virginia</u>	
24. FUNERAL DIRECTOR <u>GASCH'S</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN lb <u>6 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		d. STREET ADDRESS <u>2015 ROANOKE AVE.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. & HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GRAHAM CRAWFORD FULLER</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/1914</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT PK. CO</u>		11. BIRTHPLACE (County & State or foreign country) <u>ILLINOIS</u>	
12. CIT. ZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>EDWARD S. FULLER, JR.</u>	
14. MOTHER'S MAIDEN NAME <u>EMMA L. SCHUTTLER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>578-09-9427</u>	
16. SOCIAL SECURITY NO. <u>578-09-9427</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with metastases</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1967</u> to <u>July 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 30, 1967</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>7-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Name]</u>		22d. ADDRESS <u>772 Carroll Ave Takoma Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-2-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home Washington DC</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09742

09742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN TB <u>3 Months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13107 Dumbarton Drive</u>		d. STREET ADDRESS <u>13107 Dumbarton Drive</u>	
3 NAME OF DECEASED (Type or print) <u>Mary Elizabeth Galka</u>		4 DATE OF DEATH <u>July 26, 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>January 21, 1902</u>
9 AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work night, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Joseph Luckman</u>		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Elizabeth Gressley</u>		Address <u>13107 Dumbarton Drive</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>			
DUE TO (b) <u>Atherosclerosis</u>			
DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 15</u> , 19 <u>66</u> , to <u>July 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 26</u> , 19 <u>67</u> , and that death occurred at <u>1 P</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>Stanley M. Bialek</u>		22b DATE SIGNED <u>26 July 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>Stanley M. Bialek</u>		22d ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>July 31, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Nantux Glo Pa.</u>	
24 FUNERAL DIRECTOR <u>Warner E. Pumphrey Inc.</u>		25a REC'D BY REGISTRAR <u>JUL 31 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Clark E. Wilson</u>		25c ADDRESS <u>Silver Spring, Md.</u>	

CERTIFICATE OF DEATH

00748

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in it <u>1 month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium - Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dario (None) Garcia</u>		4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-12</u> 9. AGE (In years last birthday) <u>54</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interpreter</u>		10b. K.IND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Brazil</u>		12. CITIZEN OF WHAT COUNTRY? <u>Brazil</u>	
13. FATHER'S NAME <u>Lino Garcia</u>		14. MOTHER'S MAIDEN NAME <u>Leopoldina Doehorn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>TOXEMIA</u> DUE TO (b) <u>ASSOCIATED WITH JAUNDICE AND PERITONITIS</u> DUE TO (c) <u>CARCINOMA OF PANCREAS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>100 days</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> to <u>July 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 28, 1967</u> , and that death occurred at <u>11:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W. W. Bantman</u>		22b. DATE SIGNED <u>7-28-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>July 31-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Madisonburg, Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09744

08749

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN lb 17 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 11901 Parkton Place e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Miss Zeda Ruth George First Middle Last		4. DATE OF DEATH Month Day Year July 10, 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-01
9. AGE (In years last birthday) 66 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-retired	11. BIRTHPLACE (County & State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME Charles George	
14. MOTHER'S MAIDEN NAME Emma Lohr		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Patient's chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4161 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Infarction DUE TO (c) Rheumatic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 weeks 3 1/2 weeks Many years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct , 1962, to July 9 , 1967, that (I) (we) last saw the deceased alive on July 9 , 1967, and that death occurred at 12:30 AM, from causes and on the date stated above.			
22a. SIGNATURE Robert D. Irey		22b. DATE SIGNED July 10, 1967	
22c. PHYSICIAN'S NAME (Type) ROBERT D. IREY		22d. ADDRESS 11161 New Hampshire Ave, Silver Spring	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-12-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) Jenner, Penna.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 13 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

09745

CERTIFICATE OF DEATH

09750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u>		c. LENGTH OF STAY IN TB <u>30 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8809 Kensington Parkway</u>		d. STREET ADDRESS <u>8809 Kensington Pkwy</u>	
3. NAME OF DECEASED (Type or print) <u>Laura McChesney Gilliland</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1886</u>
9. AGE (in years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
13. FATHER'S NAME <u>James Gilliland</u>		14. MOTHER'S MAIDEN NAME <u>Alice McChesney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-01-0772</u>	
17. INFORMANT <u>Sister</u>		18. ADDRESS <u>Same as Item 2.</u>	
19. NAME <u>Mary Elizabeth Gilliland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1966</u> to <u>present</u> , that (I) (we) lost saw the deceased alive on <u>7/6 1967</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umhau</u>		22b. DATE SIGNED <u>7/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU MD</u>		22d. ADDRESS <u>8805 Conn Ave. Chevy Chase Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-11-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

09746

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c LENGTH OF STAY IN TB <u>3/23/1967</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Silver Spring Nursing Home</u>		e STREET ADDRESS <u>9505 Saubrook Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Barbara D. Glatfelter</u>		4 DATE OF DEATH Month <u>7</u> Day <u>22</u> Year <u>1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>CAUC.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/17/1908</u>
9 AGE (In years last birthday) <u>79</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>2</u> Days <u>2</u> Hours <u>7</u> Min <u>0</u>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11b KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11c BIRTHPLACE (County & State, or foreign country) <u>COLUMBIA, OHIO</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Dave Wilson</u>		14 MOTHER'S MAIDEN NAME <u>Saviors</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>216507054</u>	
17 INFORMANT <u>Mary Louise Brown</u>		Address <u>126 Normandy Drive Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Massive</u> DUE TO (b) <u>Cerebro Sclerosis</u> DUE TO (c) <u>Cerebral Thromboses Multiple</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Generalized Arteriosclerosis - Hypertensive Heart Disease</u>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 17, 1963</u> to <u>July 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 13, 1967</u> , and that death occurred at <u>7 A.M.</u> from causes and on the date stated above			
22a SIGNATURE <u>George L Ball</u>		22b DATE SIGNED <u>July 22, 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>George L Ball</u>		22d ADDRESS <u>10620 Georgia Avenue Silver Spring, Md.</u>	
23a BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		23b DATE THEREOF <u>July 25, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24a FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		24b ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>	
25a REC'D BY REGISTRAR <u>JUL 25 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. J. J.</u>	

Medical Examiner Dr. Beldor Reap to be placed in this case and he got hospitalized. He to sign this certificate. The law requires that the death certificate be executed within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office by return mail. PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1-67

Items 18-21 Film 391 8-3 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09747

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03752

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 2, Gaithersburg, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS			
3 NAME OF DECEASED (Type or print) First Robert Middle Charles Last Goad				4 DATE OF DEATH Month 7 Day 20 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/25/38		9 AGE (In years last birthday) yrs 29		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Montgomery County		11 BIRTHPLACE (State or foreign country) Washington, D. C.		12 CITIZENSHIP OF WHAT COUNTRY? USA	
13 FATHER'S NAME Floyd Goad				14 MOTHER'S MAIDEN NAME Anna Kahl			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 220-34-4301		17 INFORMANT Address Wife, Betty Goad, Gaithersburg, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple extreme injuries including DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) fractured skull and exsanguination DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Deceased driving vehicle which collided with truck.					
20c. TIME OF INJURY Month Day, Year 7/20/19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office, bldg., etc.) Street		20f. (City or town) (County) (State) Damascus Montgomery Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles Juarez Address (Street, city, county or state) 7/21/1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-24-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor		23d. LOCATION (City or town) (County) (State) Etchison Mont. Md.	
24. FUNERAL DIRECTOR ADDRESS Francis H. Barber Laytonsville, Md.				25a. REC'D BY REGISTRAR DATE JUL 25 1967		25b. REGISTRAR'S SIGNATURE Charles Juarez	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09748

09753

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 13 DAYS		2 USUAL RESIDENCE (Where deceased lived, if not in an residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS 16 THOMAS ST.	
3. NAME OF DECEASED (Type or print) DOROTHY SAVIERS GONZALEZ		4. DATE OF DEATH Month 7 Day 26 Year 19 67		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-31-97	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE		11. BIRTHPLACE (County & State, or foreign country) INDIANA	
13. FATHER'S NAME GEORGE SAVIERS			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 315-18-7997		17. INFORMANT MEDICAL RECORD DEPT.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO (b) Occlusion, Rt. Coronary artery DUE TO (c) Arteriosclerotic Heart disease					INTERVAL BETWEEN ONSET AND DEATH 7 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1966 to July 26, 1967 , that (I) (we) lost saw the deceased alive on July 25, 1967 , and that death occurred on July 26, 1967 at 1:10 PM , from causes and on the date stated above.					
22a. SIGNATURE Frederick Moomau, M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7-27-67	
22c. PHYSICIAN'S NAME (Type) FREDERICK MOOMAU, M. D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/28/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	
23d. LOCATION (City or Town) Prince George Co., Md.		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR JUL 31 1967	
25b. REGISTRAR'S SIGNATURE [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>7524 Hampden Lane</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Mary F Goodwin</u>		4 DATE OF DEATH Month Day Year <u>July 29 1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-89</u>
9. AGE (in years last birthday) <u>77</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Maine</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Edward P. Dore</u>		14. MOTHER'S MAIDEN NAME <u>Sarah F. Patten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Daughter</u>		Address <u>Virginia G. Rolnick Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardio-respiratory Failure</u> DUE TO (b) <u>Carcinomatous</u> DUE TO (c) <u>Ca. Head of Pancreas</u>			INTERVA. BETWEEN ONSET AND DEATH <u>6 mos</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>29 June 1967</u> , that (I) (we) last saw the deceased alive on <u>28 June 1967</u> , and that death occurred at <u>4:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John M. Wyman</u>		22b. DATE SIGNED <u>7/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. WYMAN</u>		22d. ADDRESS <u>7801 Norfolk Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>EXXON Oak Hill Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

24 hours after death. Page 4
The law requires that the death certificate be executed by the attending physician and completely retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely retained by the hospital or attending physician, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.
09750
CERTIFICATE OF DEATH
09755

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8310 Draper Lane</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8310 Draper Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First <u>G.</u> Middle <u>Gravely</u> Last		4. DATE OF DEATH <u>July</u> Month <u>5</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>	
13. FATHER'S NAME <u>Oliver W. Catlett</u>		14. MOTHER'S MAIDEN NAME <u>Lucy P. Lake</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Mrs. David Mc Kay</u> Address <u>8310 Draper Lane</u> <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma Liver</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Adenocarcinoma Left Breast</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9 months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that (I) (the hospital) attended the deceased from <u>1950</u> to <u>July 5</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>July 5</u> , 19 <u>67</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Earl H. Mitchell</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl H. Mitchell</u>		22d. ADDRESS <u>2029 2 St., NW, Washington, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 8, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
23d. LOCATION (City, town or county) <u>Suitland, Maryland</u>		23e. REC'D BY REGISTRAR <u>Charles Judge</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		24a. ADDRESS <u>434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		24b. DATE <u>JUL 7 1967</u>	

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u></p> <p>c. LENGTH OF STAY IN b. _____</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p><u>111 Lee Ave.</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Md.</u></p> <p>b. COUNTY <u>Montgomery</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u></p> <p>d. STREET ADDRESS <u>111 Lee Ave.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p>First Middle Last <u>Effie Columbia Green</u></p>		<p>4. DATE OF DEATH</p> <p>Month Day Year <u>July 24 1967</u></p>	
<p>5. SEX <u>F</u></p> <p>6. COLOR OR RACE <u>W</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>11/29/77</u></p> <p>9. AGE (in years last birthday) <u>89</u> yrs.</p> <p>10. UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>	
<p>11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nurse/writer</u></p> <p>11b. KIND OF BUSINESS OR INDUSTRY _____</p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>	
<p>13. FATHER'S NAME <u>John Williams</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Matvenia Baukley</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>218-54-6466</u></p> <p>17. INFORMANT <u>Ivy Green 111 Lee Ave.</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Congestive heart failure</u></p> <p>DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u></p> <p>(a), stating the underlying cause last } DUE TO (c) _____</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u></p> <p><u>15 yrs</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).</p> <p><u>Metastatic intra cranial tumor, (? primary site)</u></p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p> <p>20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____</p> <p>20f. (City or town) _____ (County) _____ (State) _____</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from July 1966 to July 24 1967 that (I) (was) last saw the deceased alive on July 24 1967, and that death occurred at 8 PM, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>John D. Guswold</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>John D. Guswold MD</u></p>		<p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p> <p>22d. ADDRESS <u>4830 "V" St N.W. DC.</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u></p>		<p>23b. DATE THEREOF <u>7/27/67</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l Park Cemetery</u></p>	
<p>24 FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u></p>		<p>25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUL 28 1967</u></p> <p>25b. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>	

09752

CERTIFICATE OF DEATH

03757

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cleary,</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		e. STREET ADDRESS <u>13431 Doncaster Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Katie Alameda Gregory</u>		4. DATE OF DEATH Month <u>July</u> Day <u>25th</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/24/10</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Henry Potter</u>		14. MOTHER'S MAIDEN NAME <u>Kathleen Mitchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>Yes</u>	
17. INFORMANT <u>Rev. Edmond Gregory</u> <u>Hosp. Records</u>		Address <u>13431 Doncaster Dr.</u> <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>170X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of breast</u> DUE TO (b) <u>generalized metastases</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 1967, to <u>July 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1967</u> , and that death occurred at <u>2:57 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. A. Dement Bonifant</u>		22b. DATE SIGNED <u>July 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. Dement Bonifant</u>		22d. ADDRESS <u>Medical Center, Sandy Spring, Md.</u>	
23a. 8. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>July 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Goshen Baptist Church Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Brunswick County North Carolina</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR <u>Charles J. J. J.</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles J. J. J.</u>		DATE <u>JUL 27 1967</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		d STREET ADDRESS 4903 BATTERY LANE	
3 NAME OF DECEASED (Type or print) First PETER Middle JOHN Last GREGORY		4 DATE OF DEATH Month JULY Day 30 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/1890
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Candy	
11. BIRTHPLACE (County & State, or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN GREGORY		14. MOTHER'S MAIDEN NAME AMANDA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 78-23-7944	
17. INFORMANT WIFE, ANNA GREGORY (SAME AS ABOVE)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory arrest 334X DUE TO (b) Cerebral atherosclerotic Bulbar palsy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) General PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General aging processes		INTERVAL BETWEEN ONSET AND DEATH Immediate years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 12 , 19 66 , to July 29 , 19 67 , that (I) (we) last saw the deceased alive on July 29 , 19 67 , and that death occurred at 8:54 A M, from causes and on the date stated above.			
22a. SIGNATURE Allen J. O'Neill		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ALLEN J. O'NEILL		22d. ADDRESS 8601 Old Georgetown Rd Bethesda Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-1-67	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR AUG 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09754

Item 4 Filed 7/28/67
CERTIFICATE OF DEATH

09759

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN b 11 mos. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 11711 Lovejoy St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lillian Ethel Griffin			4. DATE OF DEATH Month July Day 11 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1882		9. AGE (In years last birthday) 84 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Louisville, Kentucky	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME ? Lightfoot		
14. MOTHER'S MAIDEN NAME (unknown)			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. none			17. INFORMANT 11711 Lovejoy Street Mrs. Dee Wender-Silver Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO as CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 days long period
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia Carcinoma of the Colon					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 67 , to July 11 , 19 67 , that (I) (we) last saw the deceased alive on July 11 , 19 67 , and that death occurred at 7 P M, from causes and on the date stated above.					
22a. SIGNATURE Russell C. Bufalino		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Russell Bufalino, M.D.		22d. ADDRESS 1429 University Blvd., West Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 15, 1967		23c. NAME OF CEMETERY OR CREMATORY ELMWOOD CEM.	
23d. LOCATION (City or Town) (County) (State) Birmingham, Ala.		24. FUNERAL DIRECTOR W.W. Chambers Co. 1400 Chapin St. N.W. Wash., D.C.			
25a. REC'D BY REGISTRAR JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

09755

CERTIFICATE OF DEATH

69750

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE WASH., DC. b. COUNTY S.E.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3827 "W" STREET, S.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE A. GROVE		4 DATE OF DEATH Month Day Year 7 21 1967	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-18
9. AGE (in years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months Days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Bkkg.		12. KIND OF BUSINESS OR INDUSTRY Felman Co.	
13. BIRTHPLACE (County & State, or foreign country) Penna.		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Harry G. Carter		16. MOTHER'S MAIDEN NAME Alice Horner	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO 579-01-2991	
19. INFORMANT Joseph R. Haney - Same as #2		Address	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5-4-65	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
24a. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	24b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	24d. (City or town) (County) (State)
25. I certify that (I) (this hospital) attended the deceased from 7/21, 1965 to 7/21, 1967 , that (I) (we) lost saw the deceased alive on 7/21, 1967 , and that death occurred at 3 P M, from causes on and on the date stated above			
26a. SIGNATURE G. Leonard Boyd M.D.		26b. DATE SIGNED 7/22/67	
26c. PHYSICIAN'S NAME (Type)		26d. ADDRESS	
27a. BURIAL, CREMATION, REMOVAL (Specify) Burial	27b. DATE THEREOF 7/25/67	27c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.	27d. LOCATION (City or Town) (County) (State) Fort Myer Virginia
28. FUNERAL DIRECTOR E. W. Foster - Lee Funeral Home		28a. REC'D BY REGISTRAR DATE JUL 25 1967	28b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 (4)
25M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/64

09756

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>4422 68th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>—</u> Middle <u>—</u> Last <u>Haack</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22 1907</u>
9. AGE (in years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - Prince George's</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Russell F. Haack</u>		14. MOTHER'S MAIDEN NAME <u>Beverly Ann Bucher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father</u>		Address <u>as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1967</u> to <u>July 22, 1967</u> that (I) (we) last saw the deceased alive on <u>July 22, 1967</u> , and that death occurred at <u>4:20 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Roberto Casas</u>		22b. DATE SIGNED <u>7-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Roberto Casas, M.D.</u>		22d. ADDRESS <u>1105 SPRING ST., SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of "Heaven Cemetery"</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. SIGNED BY REGISTRAR <u>James J. Judge</u>	
25a. ADDRESS <u>1991 Rockville Road, Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>	
DATE <u>JUL 31 1967</u>			

CERTIFICATE OF DEATH

09762

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>year.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>734 Carr Ave</u>		d. STREET ADDRESS <u>734 Carr Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Gladys S. Haller</u>		4 DATE OF DEATH <u>July 28 1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-14-10</u>
9 AGE (In years last birthday) <u>57</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>dress shop</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wm. Shultz</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE PEPPER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>187-16-4802</u>	
17 INFORMANT <u>Husband - 734 Carr Ave, Rockville, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 17</u> , 19 <u>67</u> to <u>July 28</u> , 19 <u>67</u> , that (I) (<u>not</u>) last saw the deceased alive on <u>July 20</u> , 19 <u>67</u> , and that death occurred at <u>12:5 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen C. Cromwell</u>		22b. DATE SIGNED <u>7-28-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	23d. LOCATION (City or Town) (County) (State) <u>Beardsville Monty. Md</u>
24. FUNERAL DIRECTOR <u>Hilton Funeral Home Beardsville Md</u>		25a. REC'D BY REGISTRAR <u>AUG 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

09758

09753

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission), a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN TB <u>3 days</u>		d. STREET ADDRESS <u>7401 New Hampshire Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Andrew Jackson Harrison</u>		4. DATE OF DEATH <u>July 26</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-92</u>
9. AGE (In years lost birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief of Procurement Veterans Admin.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Andrew Jackson Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Rose Eagan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes U.S. Army WWII</u>		16. SOCIAL SECURITY NO <u>216-46-0108</u>	
17. INFORMANT <u>MARY K. HARRISON</u> <u>Retiree's chart</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prima</u> DUE TO (b) <u>Chronic urinary retention</u> DUE TO (c) <u>6 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ischemia</u> <u>Arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>7-10-</u> 19 <u>67</u> , to <u>7-26</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-26</u> 19 <u>67</u> , and that death occurred at <u>4:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Seruch T. Kirble</u>		22b. DATE SIGNED <u>7-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kirble</u>		22d. ADDRESS <u>927 Pershing Dr., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>July 31, 1967</u>	<u>New Cathedral Cemetery</u>	<u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Walter E. Pumphrey, Inc.</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
25a. ADDRESS <u>8434 Georgia Avenue, Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

09759

09764

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN IB <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d. STREET ADDRESS <u>Route #3</u>	
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>Wayne</u> Last <u>Hartman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1958</u>
9. AGE (In years last birthday) <u>8</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> M.n. <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harvey E. Hartman</u>		14. MOTHER'S MAIDEN NAME <u>Shirley L. Mullinix</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>The Medical Records</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Lymphatic Leukemia</u> <u>2043</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from <u>(DOA) 29 July 1967</u> to <u>29 July 1967</u> that (X) (we) last saw the deceased alive on <u>(DOA) 29 July 1967</u> , and that death occurred at <u>3:30 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Robert C. Young</u>		22b. DATE SIGNED <u>29 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Young, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 31, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs Meth.</u>	23d. LOCATION (City or Town) (County) (State) <u>Poplar Springs, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Olin L. Molesworth, Damascus, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 1 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

09750

09755

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home for the Aged, Inc.		d. STREET ADDRESS 4500 Hampnett Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Blanche Simonds Henry		4. DATE OF DEATH Month Day Year July 19 1967.	
5 SEX F	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH June 30, 1885
9 AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Curtis Bennett Simonds		14. MOTHER'S MAIDEN NAME Katherine Ohlgart	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 215-54-8925 J1	
17 INFORMANT Asbury Methodist Home, Gaithersburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: a. IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage (Colon) DUE TO (b) Carcinoma of Colon DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/28/63 , 19, to 7/19/67 , 19, that (I) (we) last saw the deceased alive on 7/19/67 , 19, and that death occurred at 5:30 P.M. , from causes and on the date stated above			
22a. SIGNATURE Henry C. Scruggs, M.D.		22b. DATE SIGNED 7/19/67	
22c. PHYSICIAN'S NAME (Type) Henry C. Scruggs, M. D.		22d. ADDRESS 5413 Cedar Lane Bethesda Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/20/67.	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto, Md. 21214		25a. REC'D BY REGISTRAR JN1 21 1967	
25b. REGISTRAR'S SIGNATURE William R. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>133 Webster St N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian C. Henry</u> First Middle Last		4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-1904</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chick</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Utica M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Clem Bradley</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>579 32 3077</u>	
17. INFORMANT <u>Mrs. Russell Henry above</u> Address <u>same as</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE FAILURE</u> DUE TO (b) <u>EMPHYSEMA</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 Hrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour : m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>67</u> , to <u>JULY</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>JULY 7</u> 19 <u>67</u> and that death occurred at <u>9:50</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>7/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. LEO F. DOMAN</u>		22d. ADDRESS <u>8218 WISCONSIN AVE BETHESDA</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u>
24. FUNERAL DIRECTOR <u>Ronald M. Etchison & Son, Frederick, Maryland</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUL 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09762		09767	
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>6 hours</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>154</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hosp</u>		d. STREET ADDRESS <u>7411 Flower Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Thekla Dorothea Herwick</u>		4 DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 2, 1885</u>
9 AGE (In years lost birthday) <u>82 yrs</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Norway</u>
13. FATHER'S NAME <u>Edward Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Ryberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	17. INFORMANT <u>Medical Records WSH</u>
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO (b) <u>CHF.</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u> <u>20-30 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1967</u> to <u>July 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1967</u> , and that death occurred at <u>4:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R. N. Sondstrom</u>		22b. DATE SIGNED <u>7-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. N. Sondstrom MD</u>		22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>July 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Sanitarium</u>	23d. LOCATION (City or town) (County) (State) <u>Georgetown, Md.</u>
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>254 Carroll St - RG</u>	25b. REGISTRAR'S SIGNATURE <u>Jul 11 1967</u>

09763

CERTIFICATE OF DEATH

09768

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>19 Argyle Street</u>		d. STREET ADDRESS <u>19 Argyle Street</u>	
3. NAME OF DECEASED (Type or print) <u>KATE</u> First <u>HYATT</u> Middle <u>HIGGINS</u> Last		4. DATE OF DEATH <u>July 27,</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 1894</u>
9. AGE (in years last birthday) <u>72</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N. Carolina</u>
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James L. Hyatt</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Griffith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Clara Lee Hyatt-Item # 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Severe diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>July 27, 1967</u> , to <u>July 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1967</u> , and that death occurred at <u>1:30 P.M.</u> from causes on and the date stated above			
22a. SIGNATURE <u>Corinne Cooper</u>		22b. DATE SIGNED <u>7/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u>		22d. ADDRESS <u>104 S. Washington St., Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	23b. DATE THEREOF <u>7/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gaston Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Gastonia, N. Carolina</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Sudden death cleared with Medical Examiner Dr. John Hall.

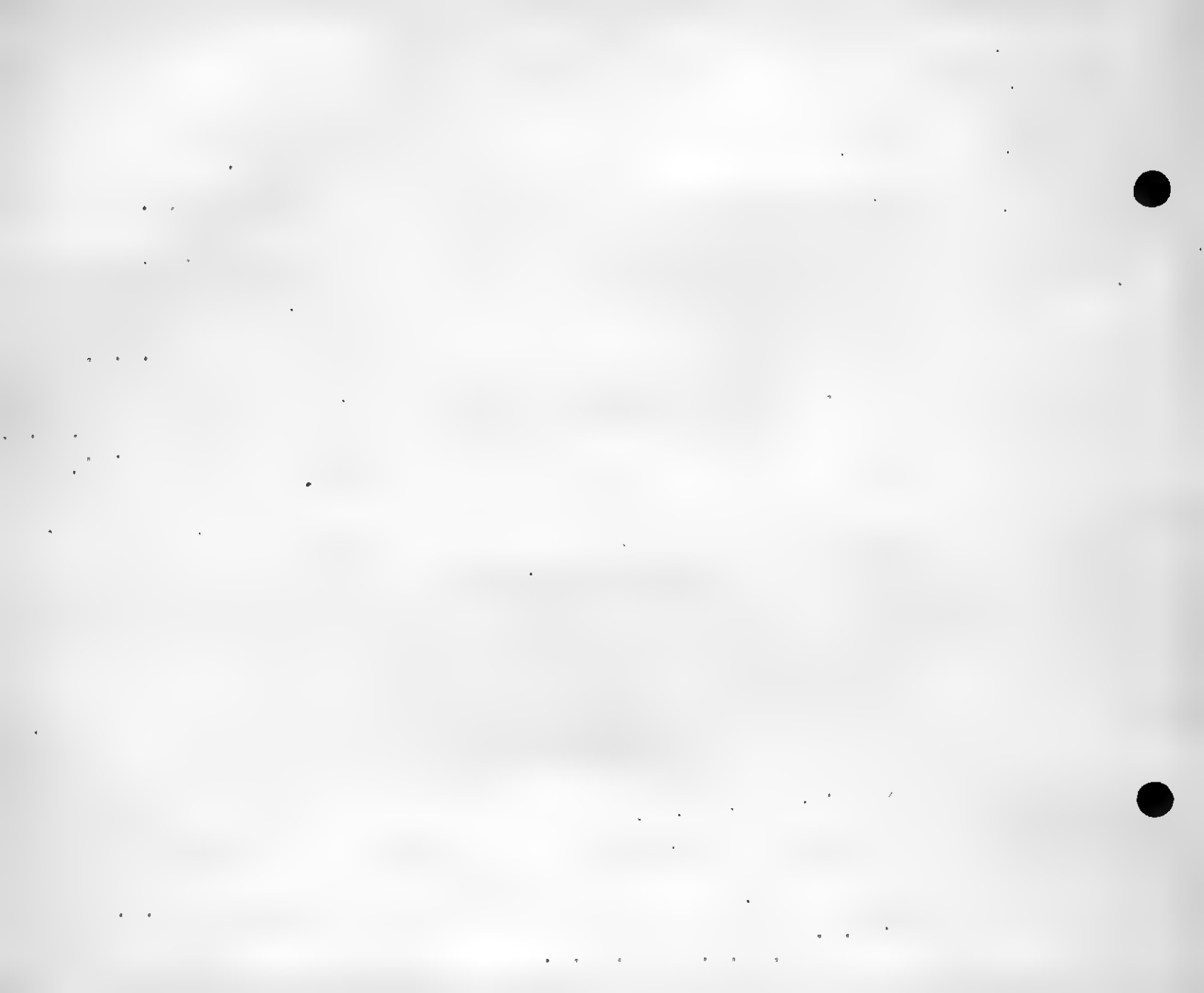


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner (Deputy) notified & approved -

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 4321 Argyle Terrace N.W.					
3. NAME OF DECEASED (Type or print) First Virginia Middle Ann Last Hildebrand						4. DATE OF DEATH Month July Day 30 Year 1967					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/3/85		9. AGE (In years last birthday) 82 yrs.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thornton F. Berry						14. MOTHER'S MAIDEN NAME Lucy Hicks					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Julia Mushinsky 5842 Oregon Ave. N.W. Washington, D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Myocardial Infarction DUE TO (b) Chronic Myocardial ischemia DUE TO (c) Atherosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										INTERVAL BETWEEN ONSET AND DEATH 2 days chronic 4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 30, 1967 to July 30, 1967 , that (I) did saw the deceased alive on July 28, 1967 , and that death occurred at 6:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE E. W. Nicklas						22b. DATE SIGNED Aug 1 1967		22c. PHYSICIAN'S NAME (Type) E. W. Nicklas			
22d. ADDRESS 4830 - 1st N.W.						22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 8/1/67		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Wash. D.C.						25a. REC'D BY REGISTRAR AUG 1 1967 25b. REGISTRAR'S SIGNATURE Charles J. J...					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09765 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09770											
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c LENGTH OF STAY IN 1b						2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince George's</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hospital</u>						d. STREET ADDRESS <u>813 Colby Ave.</u>					
3 NAME OF DECEASED (Type or print) <u>Martha J. Hill</u>						4 DATE OF DEATH <u>7</u> <u>4</u> <u>1967</u>					
5 SEX <u>Female</u>		6 COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>94</u>		9 AGE (In years last birthday) <u>94</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, DC.</u>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Isaac Baker</u>						14. MOTHER'S MAIDEN NAME <u>Lucy Washington</u>					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>				16 SOC. SEC. SECURITY NO <u>218-56-3402</u>		17 INFORMANT <u>Hattie Thurston</u> Address <u>Takoma Park, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PELVICAL Malnutrition</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>Generalized arterio Sclerosis</u>											
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.						22. DATE SIGNED <u>7/4/67</u>					
EXAMINER'S NAME (Type)						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>				23b DATE THEREOF <u>7--8-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>			23d LOCATION (City or Town) (County) (State) <u>Prince Georges, Md.</u>		
24 FUNERAL DIRECTOR <u>John T. Rhines Co</u> ADDRESS <u>3015 12th St., N.E., Wash., D.C.</u>						25a REC'D BY REGISTRAR <u>JUL 7 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

C9771

00766

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, within any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if in institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN TB <u>D.C.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HELMUTH Max</u> First Middle Last		4. DATE OF DEATH <u>July 9 1967</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 29, 1907</u> 67 yrs
9. AGE (In years birth day) <u>67</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Repair Const. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Anna (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Wife-Well-Same</u>	
17. INFORMANT <u>Wife-Well-Same</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>4 years</u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November, 1964</u> , to <u>July 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1967</u> , and that death occurred at <u>12:11 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Robert C. Macon</u> M.D.		22b. DATE SIGNED <u>7-9-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Macon</u>		22d. ADDRESS <u>809 Viers Mill Rd., Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-11-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> ADDRESS		25a. REC'D BY REGISTRAR <u>JUL 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3. TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3. TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3.

09767		DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND		09772	
Item 3 Film 6-20 6/19/67					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW JERSEY</u> b. COUNTY <u>BERGEN</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN TB <u>2 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT LEE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1710 FLORA LANE</u>		d. STREET ADDRESS <u>HORIZON HOUSE 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>THORBJORG</u> Middle <u>MARIA</u> Last <u>HOLM-ANDERSON</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1, 1911</u>	9. AGE (In years lost birthday) <u>56</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dom Home</u>		11. BIRTHPLACE (State or foreign country) <u>ICELAND</u>	
13. FATHER'S NAME <u>GISLASON, INGOLFUR</u>		14. MOTHER'S MAIDEN NAME <u>VIGFUSDOTTIR, ODDNY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>131-382525</u>		17. INFORMANT Address <u>MRS. THORS, AGUSTA 1710 FLORA LANE SILVER SPRING, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4114 ACUTE HEART FAILURE</u> DUE TO (b) <u>CHRONIC MYOCARDIAL DISEASE AND FAILURE</u> DUE TO (c) <u>CHRONIC VALVULAR HEART DISEASE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>SEVERAL YEARS</u> <u>SEVERAL YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>6/19</u> <u>1967</u> to <u>JULY 2</u> <u>1967</u> , that (1) (we) last saw the deceased alive on <u>JULY 2</u> <u>1967</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>James A. Roberts</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. ADDRESS <u>8907 GEO. AVE. SILVER SPRING, MARYLAND</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Centre, New York</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>7/6/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>EUL 5</u> DATE <u>1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

00768

CERTIFICATE OF DEATH

00773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) KENSINGTON c. LENGTH OF STAY IN 1b 11506 Lund Place, Kensington, Md. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11506 Lund Place, Kensington, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 151 11506 Lund Place, Kensington, Md. d. STREET ADDRESS Kensington, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARA MAE HOPKINS		4. DATE OF DEATH Month July Day 13 Year 19 67	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1936
9. AGE (in years lost birthday) 31 yrs		10. IF UNDER 1 YEAR Months 1 Days 13 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CARL T. CURTIS		14. MOTHER'S MAIDEN NAME LOIS WILIE-ATWATER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No none		16. SOCIAL SECURITY NO. 11506 Lund Place, James A. Hopkins Kensington, Md.	
17. INFORMANT 11506 Lund Place, James A. Hopkins Kensington, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cor. mar. thrombosis DUE TO Myocardial infarction (b) Chronic renal failure DUE TO Diabetes Mellitus (c) Diabetes Mellitus	
19. INTERVAL BETWEEN ONSET AND DEATH 3 months		20. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this-hospital) attended the deceased from 7 August, 1967 to 13 Aug, 1967 , that (I) (we) last saw the deceased alive on 3 Aug, 1967 , and that death occurred at 11 PM , from causes and on the date stated above.			
22a. SIGNATURE Ann M. Dimitroff		22b. DATE SIGNED 7/14/67	
22c. PHYSICIAN'S NAME (Type) Ann M. Dimitroff M.D.		22d. ADDRESS 11300 Woodson Ave., Kensington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 17, 1967	
23c. NAME OF CEMETERY OR CREMATORY Minden City Cem.		23d. LOCATION (City or Town) (County) (State) Minden, Nebraska	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR BETHESDA, MARYLAND	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		25c. DATE JUL 19 1967	

09769

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove call book pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roanoke</u>	
3. NAME OF DECEASED (Type or print) <u>Hugh</u> First <u>Allen</u> Middle <u>Horton</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>79</u> 9. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of Parks (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roanoke City Parks</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Silver Creek Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Horton</u>		14. MOTHER'S MAIDEN NAME <u>Melinda Woodward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>226-01-3044</u>	
17. INFORMANT <u>Little Horton - wife</u> Address <u>2918 Rosalind Ave S.W. Roanoke, Va</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with</u> DUE TO (b) <u>massive myocardial infarction sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of Angina - 6 yrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1967</u> to <u>July 3, 1967</u> , that (I) (we) lost saw the deceased alive on <u>July 3, 1967</u> , and that death occurred at <u>5:00 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Philip E. Jones</u> M.D.		22b. DATE SIGNED <u>7/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		22d. ADDRESS <u>500 Grosvenor Drive Silver Spring Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 6 - 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Roanoke - Va.</u>	
24. FUNERAL DIRECTOR <u>L. Arthur Walters</u>		25a. RECORD BY REGISTRAR <u>254 Carroll St</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

08775

08776

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>	
c. LENGTH OF STAY IN 1b <u>1 1/2 mos.</u>		d. STREET ADDRESS <u>6402 A Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY Virginia Barrett Hough</u>		4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 20, 1871</u>
9. AGE (In years last birthday) <u>95</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Loudoun County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Wilson Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Anne Elizabeth Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>579-28-3297</u>	
17. INFORMANT <u>Mrs. Georgie Holden</u>		Address <u>Same as</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-</u> DUE TO <u>Vascular Dementia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>15 years</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/1/49</u> , 19 <u>49</u> to <u>8/1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/1</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>William Brainin</u> M.D.		22b. DATE SIGNED <u>8/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		22d. ADDRESS <u>6128 Antietam Ave, Capitol Heights</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 3, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Leesburg, Loudoun Virginia</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 2 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09771

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09772

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown. Rural</u>		c. LENGTH OF STAY IN TB <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Germantown.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <u>Rural. Rt 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Green</u> Last <u>Howes</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4th</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 15th 1880</u>	
9. AGE (in years last birthday) <u>86Yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret-Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montg. Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>James R. Howes</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>J. Dorsey Howes . As No 2-</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Carcinoma of prostate</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>56</u> to <u>7/4</u> , 19 <u>67</u> , that (I) <u>last</u> saw the deceased alive on <u>7/3</u> , 19 <u>67</u> , and that death occurred at <u>10/20</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>James G. Kerkhio</u>				22b. DATE <u>7/5/67</u>		22c. PHYSICIAN'S NAME (Type) <u>James G. Kerkhio</u>	
22d. ADDRESS <u>DAMASCUS, MD</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-6-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Presbyterian</u>		23d. LOCATION (City, town or county) (State) <u>Germantown. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner</u>				25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jorg</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09772

CERTIFICATE OF DEATH

09772

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE D.C. 20007 b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASH.	
c. LENGTH OF STAY IN 1b 3 MO. 7 DAYS		d. STREET ADDRESS 2406 19TH ST N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRLAND NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH B. HUMMEL		4. DATE OF DEATH Month 7 Day 17 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-28-88
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -o-		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) DAYTON Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LEWIS BOOK WALTER		14. MOTHER'S M.A.DEN NAME ANNA GUTNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 218-34-7134B	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis with (c) chronic brain syndrome		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July, 1965 , to 17 July, 1967 , that (I) (we) lost saw the deceased alive on 17 July 1967 , and that death occurred at 8:54 M , from causes and on the date stated above			
22a. SIGNATURE William Harvey M.D.		22b. DATE SIGNED 17 July 67	
22c. PHYSICIAN'S NAME (Type) William Harvey M.D.		22d. ADDRESS 2121 Penn Ave NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-20-67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Lee Funeral Home 300 4th St. NE Wash., D.C.		25a. REC'D BY REGISTRAR 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09773

CERTIFICATE OF DEATH

09773

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb. Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1220 Blair Mill Road		d. STREET ADDRESS 1220 Blair Mill Road	
3. NAME OF DECEASED (Type or print) ALBERT		4. DATE OF DEATH July 31, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/14
9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR: Months 53 Days 53 Hours 53 Min 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacture Rep		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Norman Hyatt		14. MOTHER'S MAIDEN NAME Rose Krasner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 168-07-2705	
17. INFORMANT Ronald Hyatt, Son, (See 2 above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Acute PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. MEDICANT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/25 , 19 67 , to 7/31 , 19 67 , that (I) (we) lost saw the deceased alive on 7/25 , 19 67 , and that death occurred at 3:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE Herbert Wechsler M.D.		22b. DATE SIGNED 8/1/67	
22c. PHYSICIAN'S NAME (Type) Herbert Wechsler		22d. ADDRESS 1800 E. St. N.W. Wash	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/2/67	23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cem.	23d. LOCATION (City or Town) (County) (State) Washington, Pa.
24. FUNERAL DIRECTOR Goldberg Funeral Home - 4217 9th Street N.W.		25a. REC'D BY REGISTRAR AUG 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>														
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>2112 Dexter Court</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Mont</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>2112 Dexter Court</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <i>FLORENCE</i> Middle <i>EMILY</i> Last <i>INSOE</i>			4. DATE OF DEATH Month <i>July</i> Day <i>15</i> Year <i>1967</i>			5. SEX <i>Female</i>			6. COLOR OR RACE <i>White</i>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>Feb. 15, 1903</i>			9. AGE (in years last birthday) <i>64</i> yrs. IF UNDER 1 YEAR: Months <i>6</i> Days <i>4</i> IF UNDER 24 HRS: Hours <i>1</i> Min. <i>0</i>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Kensington, Md</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Harry Jones</i>			14. MOTHER'S MAIDEN NAME <i>Annie S. Sanford</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give year or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Barnett D. Incoe</i>			Address <i>14412 N. H. Ave. SS</i>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary / Colon & Melastosis</i> 1558 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>12-15 mo</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>1946</i> to <i>15 July, 1967</i> , that (I) (we) last saw the deceased alive on <i>13 July 1967</i> , and that death occurred at <i>4:15</i> M, from the causes and on the date stated above.														
22a. SIGNATURE <i>William D. Aud</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED <i>7/15/67</i>		
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM D. AUD</i>						22d. ADDRESS <i>9006 Colverville Rd. Silver Sp. Md</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>			23b. DATE THEREOF <i>July 18, 1967</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Colmar Manor Pk. Hco. Md</i>					
24. FUNERAL DIRECTOR <i>Arthur Walters</i>						ADDRESS <i>254 Carroll St NW Wash DC</i>								
25a. REC'D BY REGISTRAR <i>Charles Judge</i>						25b. REGISTRAR'S SIGNATURE								
DATE <i>JUL 19 1967</i>														



09775

CERTIFICATE OF DEATH

00739

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN lb <u>TENNINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SYLVAN MANOR HEALTH CARE CENTER 9907 OLD SPRING ROAD</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>IZAKOFF</u> Last <u>IZAKOFF</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 25 1884</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>24</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
3. FATHER'S NAME <u>ISAIDORE POLONSKY</u>		14. MOTHER'S MAIDEN NAME <u>EDITH LEAH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>DONE</u>	
17. INFORMANT <u>MORTON A. ROSEN</u>		Address <u>SAME AS 21</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-4-1967</u> to <u>7-6-1967</u> , that (I) (we) lost the deceased alive on <u>7-4-1967</u> , and that death occurred at <u>4:00 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Irwin H. Ardani</u>		22b. DATE SIGNED <u>7-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRWIN H. ARDANI, M.D. 1712-I-5th N.W. WASH. D.C.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE MD</u>
24. FUNERAL DIRECTOR <u>GEORGE FUNERAL HOME 4217 9th St NW</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 10 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00781

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09776

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMB, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c LENGTH OF STAY IN lb <u>24 days</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Spencerville</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Suburban Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Ida May Jackson</u>		4 DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-17-36</u>
9 AGE (years last birthday) <u>30</u> yrs		10 IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u>		10b KIND OF BUSINESS OR INDUSTRY <u>self employed</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland, (Mont)</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Benjamin Jackson</u>		14 MOTHER'S MAIDEN NAME <u>Clara Brooks</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Army</u>		16 SOCIAL SECURITY NO. <u>Wife (Frances Jackson) same as above</u>	
17 INFORMANT Address <u>Wife (Frances Jackson) same as above</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRAIN ABSCESS</u> DUE TO (b) <u>Fract. SKULL - comminuted & compound</u> DUE TO (c) <u>Trauma -</u> Interval between onset and death <u>19 days</u> <u>24 days</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1105</u>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) <u>changing truck tire blew up - rim striking head</u>	
20c TIME OF INJURY Month Day Year <u>10/10/1967</u>		20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work or Nat While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, blog, etc.) <u>Highway</u>		20f (City or town) (County) (State) <u>Rockville, Montgomery MD</u>	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Noturo causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22 DATE SIGNED <u>7/3/67</u>	
EXAMINER'S NAME (Type) <u>John B. Ball</u>		23a B.R.A. CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
23b DATE THEREOF <u>7/7/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>ROUND OAK CEMETERY</u>	
23d LOCATION (City or town) (County) (State) <u>SPENCERVILLE, MONTG. MD</u>		24 FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>ROCKVILLE, MARYLAND</u>	
25a REGISTERED REGISTRAR <u>JUL 8 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

09777

CERTIFICATE OF DEATH

00782

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>508 Beall Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Odessa (Cuban) Jarman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <u>1</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland - USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leonard Jarman</u>		14. MOTHER'S MAIDEN NAME <u>Brenda Barber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>A. Schachter</u>		Address <u>Holy Cross Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congenital heart disease manifest by</u> DUE TO 1) Aortic valvular atresia (b) <u>2) Hyperplasia of lt. ventricle</u> DUE TO 3) Subendocardial sclerosis of lt. ventricle (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestive heart failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> at work <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/19</u> , 19 <u>67</u> to <u>7/19</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/19</u> , 19 <u>67</u> and that death occurred at <u>8:35</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Tabb, M.D.</u>		22b. DATE SIGNED <u>7/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Marvin Tabb, M.D.</u>		22d. ADDRESS <u>2401 Blueridge Ave., Wheaton, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>	23b. DATE THEREOF <u>7/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jarman Family Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Richland, N. Carolina</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> <u>Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

Cleared with Dr. Kapp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09778

CERTIFICATE OF DEATH

09783

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN 1b <u>2 HRS.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Libby Cross Hospital</u>		d STREET ADDRESS <u>9316 Piney Branch Rd</u>	
3 NAME OF DECEASED (Type or print) <u>RUBY C. Jester</u>		4 DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/11/15</u>
9a AGE (In years last birthday) <u>52</u> yrs		9b IF UNDER 1 YEAR Months Days Hours Min.	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>J. William Childers</u>		14 MOTHER'S MAIDEN NAME <u>Fraunce Brooks</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>J. M. Jester</u>		Address <u>9316 - Piney Br. Road</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Carcinoma base of tongue</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>1410</u> (c) <u>12 mos.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 mos.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour am pm <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-6</u> , 1967, to <u>7-2</u> , 1967, that (I) (we) last saw the deceased alive on <u>6-30</u> 1967, and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>HARRY N. CARLTON</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED <u>7-2-67</u>
22c PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>		22d ADDRESS <u>8811 - Colesville Rd. S.S. Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>July 5-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rock Lawn</u>	23d LOCATION (City or Town) (County) (State) <u>Kickville Montgoes Md.</u>
24 FUNERAL DIRECTOR <u>Arthur Walters</u>	ADDRESS <u>254 E. Pratt St. N.Y.</u>		25a REC'D BY REGISTRAR <u>JUL 5 1967</u>
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

09778

CERTIFICATE OF DEATH

09784

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY (If not in hospital, give street address) 901 Arcolia Ave. Wheaton, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1728 Byron Street	
3 NAME OF DECEASED (Type or print) William Henry Jewell SR.		4. DATE OF DEATH Month 7 Day 22 Year 1967	
5 SEX Male	6 COLOR OR RACE Caus.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11 BIRTHPLACE (County & State, or foreign country) Leesburg, Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Jewell		14. MOTHER'S MAIDEN NAME Mary Vonacker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 218-24-3740	
17 INFORMANT Annie E. McNeely		Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum DUE TO (b) Sigmoid Colon with Metastases DUE TO (c) 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/28 , 19 67 , to 7/22 , 19 67 , that (I) (we) last saw the deceased alive on July 22 1967 , and that death occurred at 5:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE William Brainin		22b. DATE SIGNED 7/22/67	
22c. PHYSICIAN'S NAME (Type) Dr. William Brainin		22d. ADDRESS 6124 Central Ave. Capitol Heights Wash. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/25/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR W.W. Chambers Co. Inc.		25a. REC'D BY REGISTRAR 517 11th St. S.E. Washington, D.C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 27 1967	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09780

09785

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Md.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. & Hospital</u>		e. STREET ADDRESS <u>8521 Glenview Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH JONES</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-07</u> <u>59</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Good Acres</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Marie Henderson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line: (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4</u> <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Coronary Artery Heart Disease</u> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Read</u>		22. DATE SIGNED <u>July 31, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ, M.D.</u>		23. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-3-67</u>	23c. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>John T. Rhines Co</u>		25a. REC'D BY REGISTRAR <u>August 7 1967</u>	
Funeral Home <u>Street, N. E. Washington, D. C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09781

CERTIFICATE OF DEATH

00786

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>10mo 9da</u>		d. STREET ADDRESS <u>4510 Conn. Ave N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens San.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JNA B Jordan</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19, 1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>24</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Clerk</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO <u>579-60-678</u>	
17. INFORMANT <u>Baillargeon Funeral Home</u>		Address <u>Old Town, Maine</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO (b) <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible pulmonary edema</u>			WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 4, 1967</u> to <u>July 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>JULY 4</u> 1967, and that death occurred at <u>6:32 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert S. Poole</u>		22b. DATE SIGNED <u>7.4.67.</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT S POOLE</u>		22d. ADDRESS <u>450 CONN AVE N.W. WASH DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>July 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lawn Dale Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Old Town, Maine</u>
24. FUNERAL DIRECTOR <u>Clark E. Wilson</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John A. Jones</u>			

09782

CERTIFICATE OF DEATH

23707

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY in 1b 1 mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 2204 Washington Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Tillie none Kaufman				4. DATE OF DEATH Month Day Year 7-9 1967			
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/23/1896	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Pecker				14. MOTHER'S MAIDEN NAME Udel Abelman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-16-9049		17. INFORMANT Mr. Morris Kaufman-2204 Washington Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) complications of anemia with DUE TO metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 8 months							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from June 6, 1967 to July 9, 1967 ; that (I) (we) last saw the deceased alive on July 9, 1967 , and that death occurred at 9:35 P.M. from causes and on the date stated above.							
22a. SIGNATURE William Brainin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/9/67			
22c. PHYSICIAN'S NAME (Type) William Brainin, M.D.		22d. ADDRESS 6056 Central Ave. (Seat Pleasant Capital Heights, Md.)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-10-67	23c. NAME OF CEMETERY OR CREMATORY National Capital Hebrew Cem. Washington, DC		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR B. Banyauckiy & Sons		ADDRESS WASHINGTON DC		25a. REC'D BY REGISTRAR 3501-14th ST NW		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

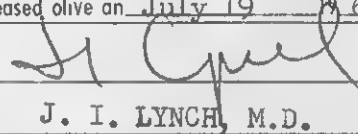

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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09783

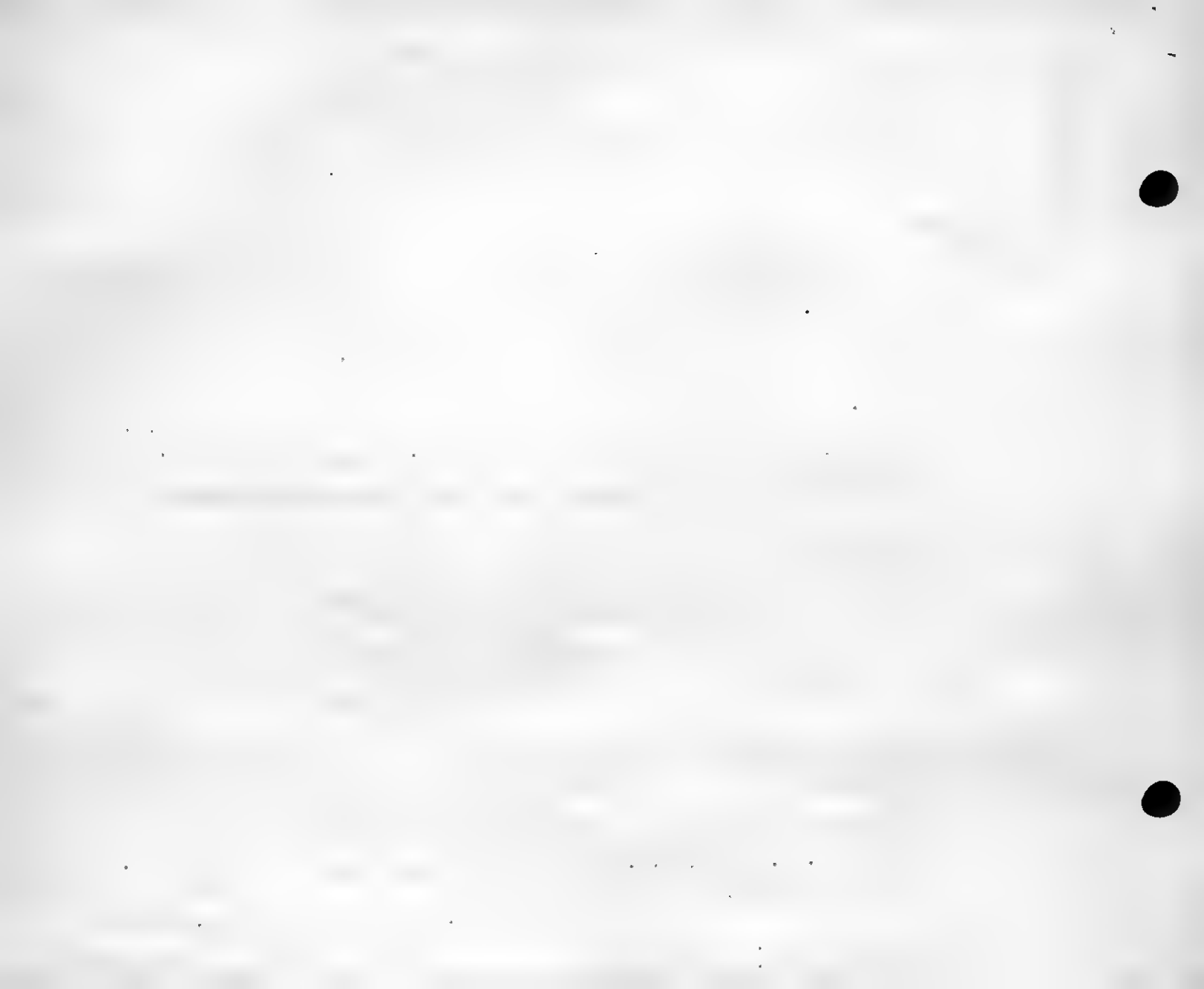
CERTIFICATE OF DEATH

09788

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE South Carolina COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY in 1b 46 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 49 Webster Street	
3. NAME OF DECEASED (Type or print) First Janet Middle Yvonne Last KERN		4. DATE OF DEATH Month July Day 19 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1963
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	9. AGE (In years last birthday) 3 yrs
11. BIRTHPLACE (County & State, or foreign country) Portsmouth, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jackson R. Kern		14. MOTHER'S MAIDEN NAME Helen Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) N/A		16. SOCIAL SECURITY NO N/A	17. INFORMANT Park, Charleston S.C. Jackson R. Kern, 49 Webster St., Menriv
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute leukemia with confluent bronchopneumonia DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2045			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from <u>June 7</u> , 19 <u>67</u> , to <u>July 19</u> , 1967, that we (we) last saw the deceased alive on <u>July 19</u> , 19 <u>67</u> , and that death occurred at <u>6:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 20 July 1967	
22c. PHYSICIAN'S NAME (Type) J. I. LYNCH, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-22-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Covington, Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR JUL 24 1967	25b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

0978

09779

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <u>3 VIRGINIA</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY in lb <u>16 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETHESDA - SILVER SPRING NURSING HOME</u>		d. STREET ADDRESS <u>3931 NORTH 30TH ST.</u>	
3. NAME OF DECEASED (Type or print) <u>WILHELMINA KIERNAK</u>		4. DATE OF DEATH Month: <u>JULY</u> Day: <u>13</u> Year: <u>1967</u>	
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BROOKLYN N.Y.</u>	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>077-24-2072</u>	
17. INFORMANT <u>GEN. CHAS. G. HOLLE</u>		Address <u>2540 MASS AVE. N.W. WASH., D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>some years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 29, 1967</u> to <u>July 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 12, 1967</u> , and that death occurred at <u>4:15 P.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>July 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. ETC</u>		22d. ADDRESS <u>1641 Colsonville Rd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or town) (County) (State) <u>Arlington Va.</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S TITLE <u>Charles Judge</u>	



1

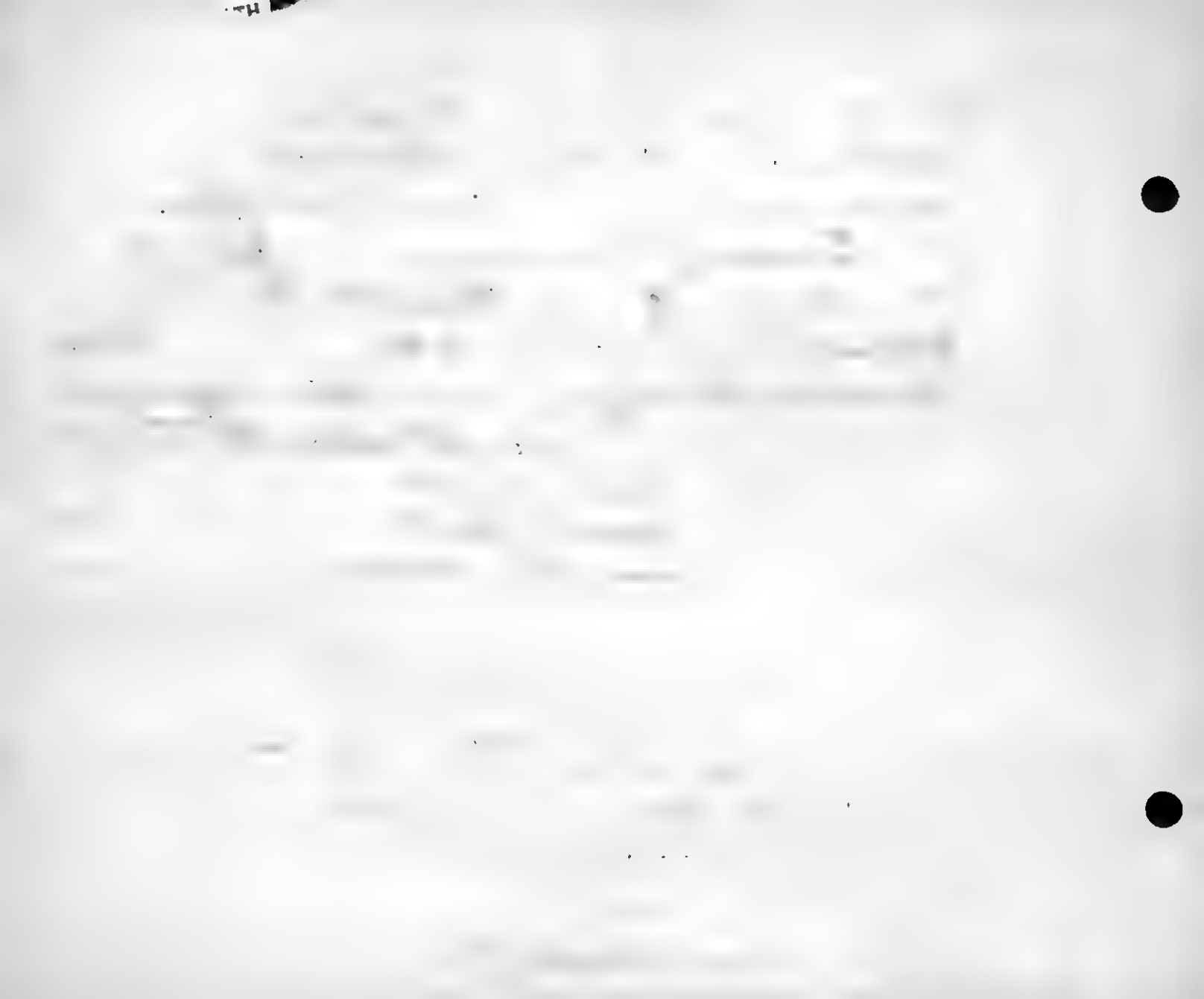


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Bethesda</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
c. LENGTH OF STAY IN 1b <i>31 hours</i>		d. STREET ADDRESS <i>7610 Arnet Lane</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edmund J. Kinney</i>		4. DATE OF DEATH <i>July 3 1967</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/26/1879</i>
9. AGE (in years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Professor</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Mathias Kinney</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Ellen Applegate</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>405-42-5320</i>	
17. INFORMANT <i>Sarah as</i>		Address <i>same as deceased above (daughter)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO (b) <i>Myocardial Infarction</i> DUE TO (c) <i>Coronary artery atherosclerosis</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			
INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i> <i>24 hours</i> <i>15 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7-2</i> , 1967, to <i>July</i> , 1967, that (I) (we) last saw the deceased alive on <i>July 2</i> 1967, and that death occurred at <i>7A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>K.H. Mish</i>		22b. DATE SIGNED <i>7-3-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>K.H. Mish</i>		22d. ADDRESS <i>3800 Jennifer St. N.W.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE THEREOF <i>7-4-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lexington</i>		23d. LOCATION (City, town or county) (State) <i>Ky.</i>	
24. FUNERAL DIRECTOR <i>Joseph Pauline Sam - Lexington D.C.</i>		25a. REC'D BY REGISTRAR <i>JUL 7 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09786

09786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>11900 Rockinghorse Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>C.</u> Last <u>Kings</u>		4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/10/02</u>
9. AGE (In years lost birthday) <u>64</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired practical nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	11. BIRTHPLACE (County & State, or foreign country) <u>China</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John A. Gere Shipley</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Wood</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO <u>232-62-1708</u>		17. INFORMANT <u>Mrs. Lenora Jew</u>	
18. ADDRESS <u>11900 Rocking Horse Road</u>		<u>Rockville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Right Temporal meningioma</u> 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Known 4 months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pituitary adenoma, pulmonary metastasis & anemia</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 21</u> , 1966, to <u>July 14</u> , 1967, that (I) (we) last saw the deceased alive on <u>July 14</u> , 1967, and that death occurred at <u>11:40 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Arnon H. Traum</u>		22b. DATE SIGNED <u>July 17 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARNON H. TRAUM M.D.</u>		22d. ADDRESS <u>7237 Georgia Ave. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 19, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u>		25a. REC'D BY REGISTRAR <u>JUL 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>38434 Georgia Avenue</u>	
25d. NAME <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25e. ADDRESS <u> </u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1000. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Item 1 & 21. 1m #33 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05792

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>)	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY IN <u>2 months</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Holy Cross Hospital</u>		e STREET ADDRESS <u>10163 Sutherland Rd</u>	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>LEO</u> Last <u>KIRBY</u>		4 DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>SEPT. 10, '86</u>
9 AGE (In years last birthday) <u>80</u> yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Mon. hrs Days hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOV'T</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John J. Kirby</u>		14 MOTHER'S MAIDEN NAME <u>Anna Mc GAVIN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>None</u>		16 SOCIAL SECURITY NO <u>215-45-9883</u>	
17 INFORMANT <u>Greg E. Kirby</u>		Address <u>10163 Sutherland Road</u>	
18 CAUSE OF DEATH (Enter only one cause per PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u> DUE TO (b) <u>1538'</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>lost.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Belden R. Reap</u>		22. DATE SIGNED <u>7/28/1967</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 1, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d LOCATION (City or town) (County) (State) <u>Washington, D. C.</u>	
24 FUNERAL DIRECTOR <u>Wm. E. Pumphrey, Inc.</u>		25a. RECD BY REGISTRAR DATE <u>AUG 1 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09788

09793

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>The Plains</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>The Plains</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frances</u> First Middle Last		4. DATE OF DEATH <u>7-9-67</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/83</u>
9. AGE (In years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Turner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Turner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son-in-Law - J. Blandford</u>		Address <u>1994 Millbrook Dr Rockville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia entire right lung</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVA. BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>65</u> to <u>7/9</u> , 19 <u>67</u> , that (I) was lost saw the deceased alive on <u>7/8</u> , 19 <u>67</u> and that death occurred at <u>6:30</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Michel M. Healy</u> M.D.		22b. DATE SIGNED <u>7/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michel M. HEALY</u> M.D.		22d. ADDRESS <u>Washington Clinic Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>-</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon</u>	23d. LOCATION (City or town) (County) (State) <u>Nicholsburyhousdown, Va.</u>
24. FUNERAL DIRECTOR <u>Louis Royton Nicholsburg, Va.</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

05704

09789

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5712 Elm St. Apt. A</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES G. KREIMER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 23, 1903</u>
9. AGE <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D. C. Transit</u>	
11. BIRTHPLACE (Country & State or foreign country) <u>Frederick County Mt. Airy, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Henry Kreimer</u>		14. MOTHER'S M maiden NAME <u>ECKER, RHODA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-10-5423</u>	
17. INFORMANT <u>Mary T. Kreimer - wife</u>		18. ADDRESS <u>Old home as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE Heart DISEASE.</u> DUE TO (c) <u>10 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>53</u> , to <u>JULY</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JULY 18</u> 19 <u>67</u> , and that death occurred at <u>4:45</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>DR. LEO E. DONOVAN</u> M.D.		22b. DATE SIGNED <u>7-26-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>8214 WILSON AVE BETHESDA</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b STATE District of Columbia c COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN b 55 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d STREET ADDRESS 1841 Columbia Road, N.W. Apt. 601	
3. NAME OF DECEASED (Type or print) First Susan Middle Olive Last KULBERG		4 DATE OF DEATH Month July Day 14 Year 19 67	
5 SEX Female	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 12, 1949
9 AGE (In years last birthday) yrs 17		IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min 17	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Bradford, Massachusetts		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Harry O. Kulberg		14 MOTHER'S MAIDEN NAME Mellicent McLagan	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOC. SEC. SECURITY NO.	
17 INFORMANT N.W. Apt. 601 Address Wash. D.C.		18 Mr. Harry O. Kulberg, 1841 Columbia Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO (b) Anoxic encephalopathy DUE TO (c) Respiratory arrest			INTERVAL BETWEEN ONSET AND DEATH 4 days 74 days 74 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) Over dose of Darvon	
20c TIME OF INJURY Month, Day, Year xx 1 May 19 67	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.) Home	20f (City or town) (County) (State) Washington D.C.
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED 7-15-67	
EXAMINER'S NAME (Type) John G. BALL		DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) Bethesda, Md.	
23a BURIAL (CREMATION) (Specify) Burial	23b DATE THEREOF 7-18-67	23c NAME OF CEMETERY OR CREMATORY Arlington National	23d LOCATION (City or town) (County) (State) Arlington, Virginia
24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home		25a REC'D BY REGISTRAR JUL 19 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		25c REGISTRAR'S SIGNATURE Charles Judge	

23a BURIAL (CREMATION) (Specify)
Burial

23b DATE THEREOF
7-18-67

23c NAME OF CEMETERY OR CREMATORY
Arlington National

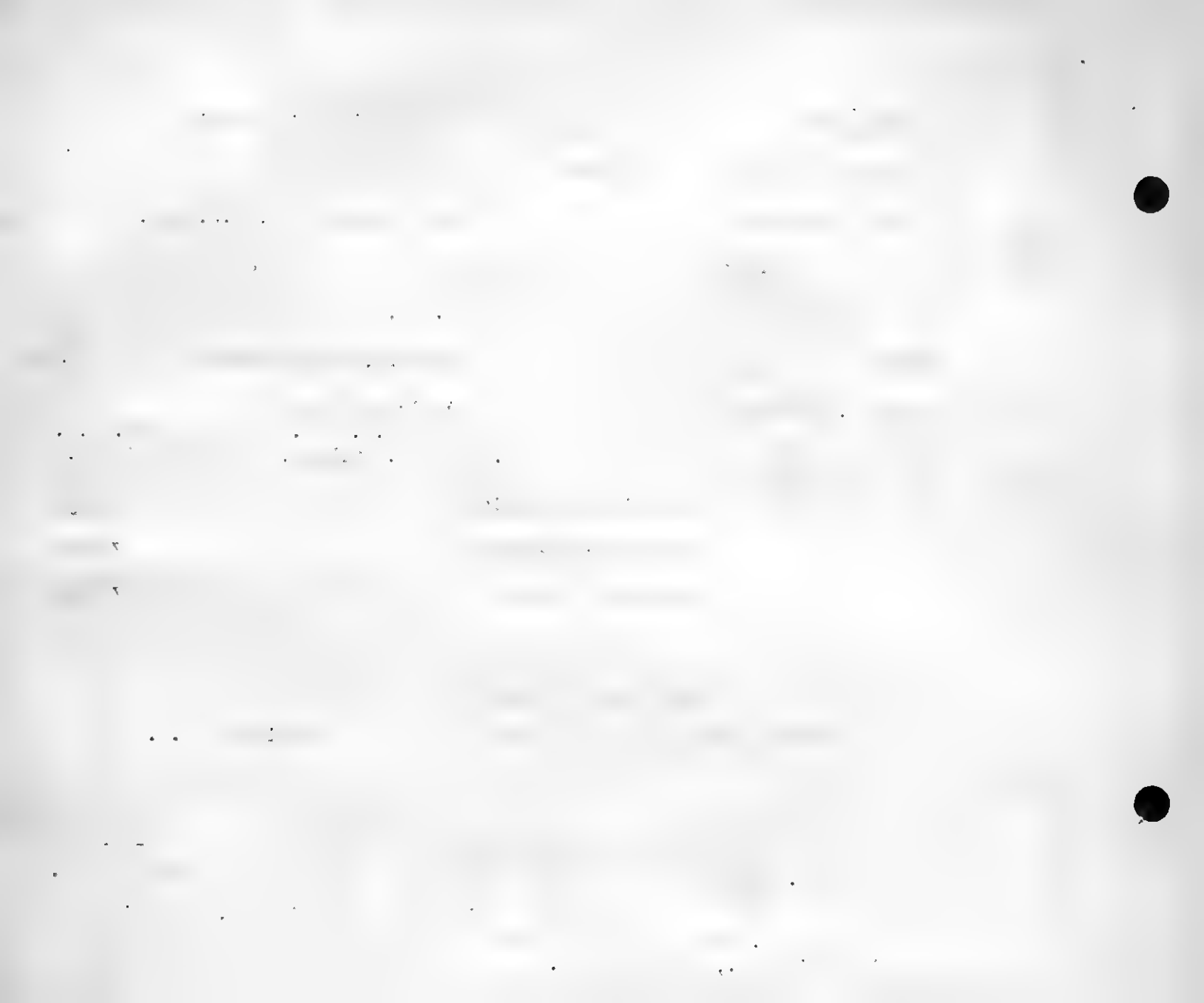
23d LOCATION (City or town) (County) (State)
Arlington, Virginia

24 FUNERAL DIRECTOR
Robert A. Pumphrey Funeral Home
7557 Wisconsin Ave., Bethesda, Md.

25a REC'D BY REGISTRAR
JUL 19 1967

25b REGISTRAR'S SIGNATURE
Charles Judge

25c REGISTRAR'S SIGNATURE
Charles Judge



08796

09791

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN <u>1 mon 3 days</u>		d. STREET ADDRESS <u>1901 XXXXXXXX Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross of Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice S. Hammer</u>		4. DATE OF DEATH <u>July 30 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-9-89</u>
9. AGE (in years last birthday) <u>77</u>		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hours <u>18</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles Faehle</u>		14. MOTHER'S MAIDEN NAME <u>Louise Hageman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>496-38-1189</u>	
17. INFORMANT <u>Mrs. Oliver F. Judge</u>		18. ADDRESS <u>10116 Tenbrook Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decomensation</u> DUE TO (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fract. R 4th. Ribs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fall in Nursing home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>6/25</u> p.m. <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 1967, to <u>7/30</u> , 1967, that (I) (we) last saw the deceased alive on <u>7/30</u> , 1967, and that death occurred at <u>8 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Norman Oliver</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>NORMAN OLIVER</u>		22d. ADDRESS <u>1400 Spring St SE Wash. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Aug. 2, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Belle Fontaine Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>St. Louis, Missouri</u>	
24. FUNERAL DIRECTOR <u>Clark E. Warner</u>		25a. REC'D BY REGISTRAR <u>Aug 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>11134 Niagara Ave Silver Spring, Md.</u>	

09792

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETESDA</u>		c LENGTH OF STAY IN 1b <u>21 1/2 HR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d STREET ADDRESS <u>2304 KANSAS AVE</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>WESLEY LANCASTER</u>		4 DATE OF DEATH Month Day Year <u>JULY 14 1967</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/96</u>
9 AGE (In years last birthday) <u>70</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE WORK</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>LANCASTER</u>		14 MOTHER'S MAIDEN NAME <u>Cecilia</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>BESSIE LANCASTER - WIFE SAME</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Primary cholangio-carcinoma, left lobe of liver</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at <u>10:47 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>George Shaye</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR <u>George R. Anorden</u>		25a REC'D BY REGISTRAR <u>Rockville Md</u>	
25b REGISTRAR'S SIGNATURE <u>John J. Jones</u>		DATE <u>JUL 18 1967</u>	



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09793

CERTIFICATE OF DEATH

09798

1 PLACE OF DEATH a COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a STATE <u>NEW YORK</u> b. COUNTY <u>Dutchess</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c LENGTH OF STAY IN 1b <u>39 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM + HOSPITAL</u>		d STREET ADDRESS <u>Pine Plains</u>	
3 NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Louina</u> Last <u>LANGDON</u>		4 DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-79</u>
9 AGE (In years, lost birthday) <u>87</u> yrs		IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM SMITH</u>		14. MOTHER'S MAIDEN NAME <u>MARY HOWARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>070-38-3489</u>	
17. INFORMANT <u>Mary J. Fitzgerald</u>		4 Manchester Place <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extensive Peritonitis</u> 5410 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Duodenal Ulcer</u> DUE TO (c) <u>3 days</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Smoking</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 20, 1964</u> to <u>July 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1967</u> , and that death occurred at <u>7:54 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Philip E. Jones</u>		22b. DATE SIGNED <u>7/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones MD</u>		22d. ADDRESS <u>800 Washington Drive Silver Spring, Md. 20910</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE HEREOF <u>July 12, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Crematory</u>		23d. LOCATION (City or town) (County) (State) <u>Prince Georges Co., Maryland</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner & Humphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09794

09799

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETESDA</u>		c. LENGTH OF STAY IN 1b <u>15 1/2 HRS.</u>		c. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN Hospital</u>				d. STREET ADDRESS <u>1514 LIVE OAK DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emily</u> Middle <u>Kane</u> Last <u>LAST</u>				4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/12</u>	9. AGE (In years lost b rthday) <u>54</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>FELIX KANE</u>				14. MOTHER'S MAIDEN NAME <u>Emily Dugan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-18-1952</u>		17. INFORMANT <u>PAUL V. LAST - HUSBAND - SAME</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO (b) <u>Coronary Artery Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>56 hrs</u> <u>36 hrs</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>21 July 1967</u> to <u>23 July 1967</u> , that (I) (we) last saw the deceased alive on <u>23 July 1967</u> , and that death occurred at <u>10:55 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Merton L. White M.D.</u>				22b. DATE SIGNED <u>23 July 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Merton L. White, M. D.</u>	
22d. ADDRESS <u>9911 Georgia Ave Silver Spring</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25d. DATE <u>JUL 27 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
09795											
09800											
1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u> c. LENGTH OF STAY IN 1b <u>75 days</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Blomberg Valley Nursing Home</u>						d. STREET ADDRESS <u>6409 East Halbert Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Rose</u> First <u>Lautman</u> Middle <u>Lautman</u> Last <u>Lautman</u>						4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4 1890</u>		9. AGE (In years lost birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State or foreign country) <u>Austria</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>CELIA STISTEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Anita Bickford Bethesda, Md.</u> Address <u>6409 E. Halbert</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>334X</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of hip - remote</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MED. CA. EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>May 3 1967</u> to <u>July 17, 1967</u> , that (I) <u>last</u> saw the deceased alive on <u>June 24 1967</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Harold C. Sadin</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <u>7/17/67</u>				22c. PHYSICIAN'S NAME (Type) <u>HAROLD C. SADIN M.D.</u>			
22d. ADDRESS <u>2141 K. St. N.W., WASHINGTON, D.C.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/18/67</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hebron</u>				23d. LOCATION (City or Town) (County) (State) <u>Flushing, Long Island, N.Y.</u>				24. FUNERAL DIRECTOR <u>Donald M. Stein</u> <u>Hebrew Memorial Funeral Home</u>			
25a. REC'D BY REG. STRAR <u>WUL 19 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

00796

CERTIFICATE OF DEATH

00891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>6</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 'b' <u>48 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn New York</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Banagher Hill Nursing Home 4011 Conboy Hall</u>				d. STREET ADDRESS <u>35 East 208th St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel Lerner</u>				4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1967</u>			
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/15/1885</u>		9 AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Romania</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Isaac Lerner</u>				14 MOTHER'S MAIDEN NAME <u>Chaya Harris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Harold Lerner, son - 14124 Banner Avenue Rockville, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Recurrent Cystitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> , 19 <u>67</u> , to <u>7/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/4</u> , 19 <u>67</u> , and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>				22d. ADDRESS <u>4115 Colie Drive, Wheaton, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, N.Y.</u>	
24 FUNERAL DIRECTOR <u>B Dargansky & Sons</u>				ADDRESS <u>Wash. D.C. 3501-14th St</u>		25a. REC'D BY REGISTRAR <u>JUL 6 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2a,b,c & d 5-11-67 pc

09797

CERTIFICATE OF DEATH

13302

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Write date of residence before admission) <u>SILVER SPRING MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write ZIP) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>Bronx</u>	
d. NAME OF HOSPITAL OR OTHER PLACE (If not in hospital, give street address) <u>Chen Chase Convalescent Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Levine Rose</u>	4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1967</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1886</u>	9. AGE (In years last birthday) <u>80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Bernard Anderhaus</u>	
14. MOTHER'S MAIDEN NAME <u>Mollie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Murray Levine, son</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>GANGRENE OF LEFT FOOT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>13 min.</u> <u>2 YEARS</u> <u>2 WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0 m</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1967</u> to <u>July 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1967</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Simon C. Weiner</u>		22b. DATE SIGNED <u>7/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Simon C. Weiner</u>		22d. ADDRESS <u>8201-16th St SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baron Hebrich Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>Staten Island, N.Y.</u>
24. FUNERAL DIRECTOR <u>B. Danyanovsky & Sons</u>		25a. REC'D. BY REGISTRAR <u>1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09757

09803

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WASH., DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 473	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		d. STREET ADDRESS 2480 16th ST., N.W.	
3. NAME OF DECEASED (Type or print) SARAH		4. DATE OF DEATH Month 7 Day 30 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 15, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHAIM BLOCHARSKY		14. MOTHER'S MAIDEN NAME RASHA ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Jeanette Behrman, rock Rd. S.S. Mo		Address 9320 Grey-	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Coronary disease DUE TO (c) Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepato-renal, Thrombogenic cause undetermined			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/15 , 19 67 , to 7/30 , 19 67 , that (I) (we) last saw the deceased alive on 7/30 , 19 67 , and that death occurred at 11:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Blaine H. H. H.		22b. DATE SIGNED July 30, 1967	
22c. PHYSICIAN'S NAME (Type) BLAINE H. H. H.		22d. ADDRESS 2641 Colson Rd. Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/31/67	23c. NAME OF CEMETERY OR CREMATORY Elesvatgrad Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR B. Danzansky + Son		25a. REC'D BY REGISTRAR AUG 1 1967	
25b. REGISTRAR'S SIGNATURE J. J. J.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>4407 Ambler Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Stewart Pierce Lewis</u>		4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-89</u>
9. AGE (In years lost birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min <u>67</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanical engineer-U.S. Government</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>275-26-4512</u>	
17. INFORMANT <u>Mary A. Lewis same as #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmonary failure</u> DUE TO (b) <u>generalized carcinomatosis</u> DUE TO (c) <u>Bronchogenic Ca.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>6 mos</u> <u>34 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/10/67</u> , 19 <u>67</u> , to <u>7/25/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John M. Wyman</u> M.D.		22b. DATE SIGNED <u>7/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. WYMAN M.D.</u>		22d. ADDRESS <u>2801 MORTFORD AVE. BETHESDA, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>7/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>JUL 26 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DR



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MEDICAL CERTIFICATE ON

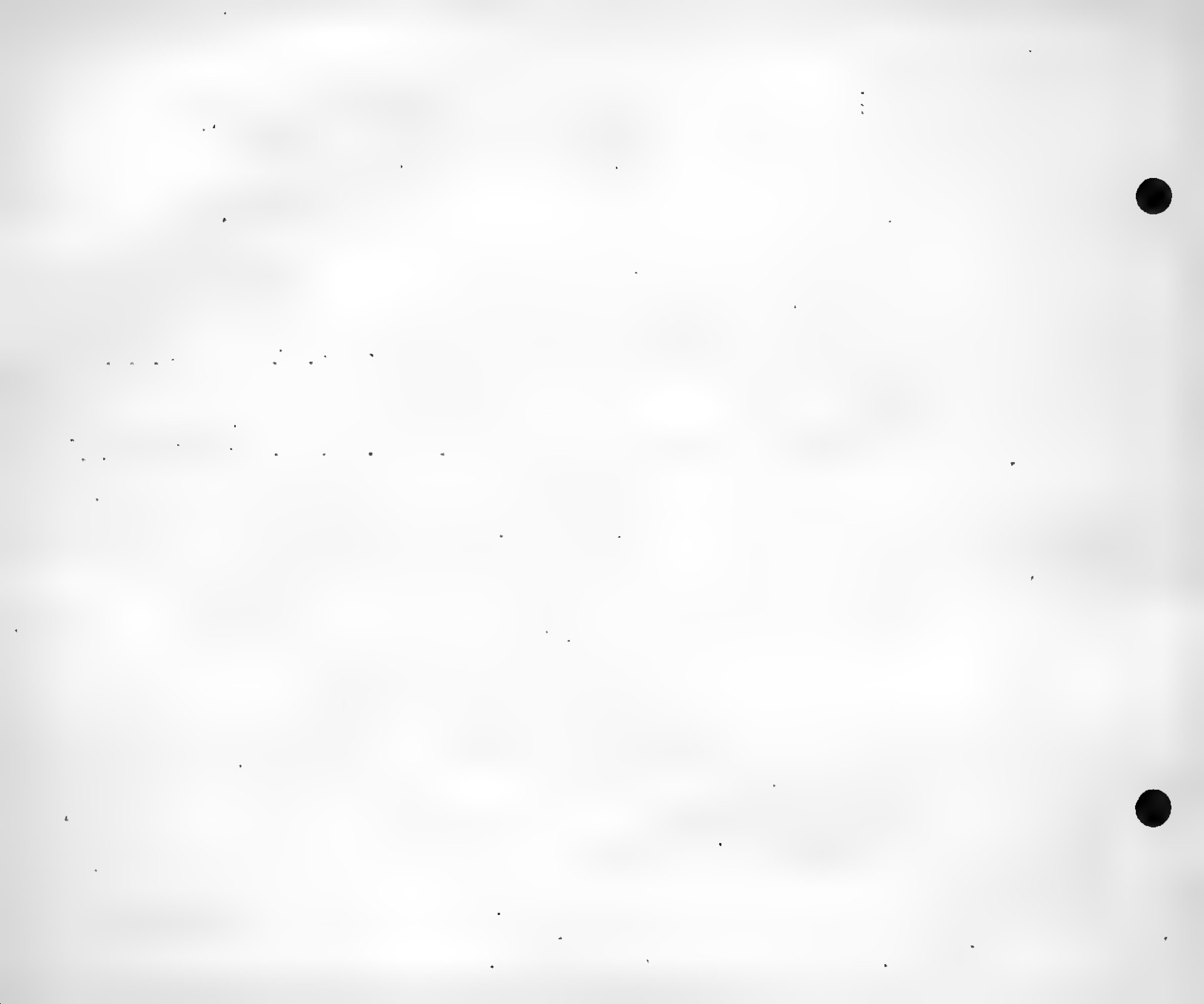
VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Clear by Medical Examiner *Belden Kay M.D. J. R. H. M.D.*

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> c. LENGTH OF STAY IN 1b <i>4 days</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4616 Harlan Street</i>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i> d. STREET ADDRESS <i>1603 Jefferson Street</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>MAIMIE ELIZABETH LOHMEYER</i> First Middle Last 4. DATE OF DEATH <i>JULY 10 1967</i> Month Day Year					5. SEX <i>female</i> 6. COLOR OR RACE <i>white</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>Dec 8, 1888</i> 9. AGE (In years last birthday) <i>78</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i> 11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i> 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					13. FATHER'S NAME <i>George Owens</i> 14. MOTHER'S MAIDEN NAME <i>Sarah Little</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> 16. SOCIAL SECURITY NO. <i>587-22-7810</i> 17. INFORMANT <i>Harry E. Lohmeyer, Jr.</i> Address <i>4616 Harlan St. Rockville, Md.</i>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis, generalized</i> DUE TO (c) <i>years</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <i>19</i> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1955</i> to <i>July 5, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 5 1967</i> , and that death occurred at <i>12:22 PM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>James R. Coleman</i> 22c. PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN</i>					22b. DATE SIGNED <i>July 10, 1967</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>9241 COLUMBIA BLVD SILVER SPRING MARYLAND</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 23b. DATE THEREOF <i>July 13, 1967</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> 23d. LOCATION (City, town or county) (State) <i>Rockville, Maryland</i>					24. FUNERAL DIRECTOR <i>Glen Carter</i> Address <i>8434 Georgia Avenue Warner E. Humphrey, Inc. Silver Spring, Md.</i> 25a. RECD BY REGISTRAR <i>JUL 13 1967</i> 25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>				



CERTIFICATE OF DEATH

00807

09802

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>36 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium + Hospital</u>		e. STREET ADDRESS <u>4404 Brookfield Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>John Alphonsis Loughran</u>		4. DATE OF DEATH <u>July 2 1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-91</u>
9. AGE (in years lost birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR <u>2</u> Months <u>19</u> Days <u>67</u> Hours <u>19</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>John Loughran</u>		14. MOTHER'S MAIDEN NAME <u>Annie Kinney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Med. records</u>		Address <u>Wash. San. Hosp.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
1561 IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u>			
DUE TO (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>uremia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/2</u> , 19 <u>65</u> , to <u>7/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/1</u> , 19 <u>67</u> , and that death occurred at <u>4:32 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Henry W. Stout MD</u>		22b. DATE SIGNED <u>7/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT MD</u>		22d. ADDRESS	
23a. BURIAL, CREMATION <u>Burial</u>		23b. DATE THEREOF <u>7-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>JUL 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>	

09803

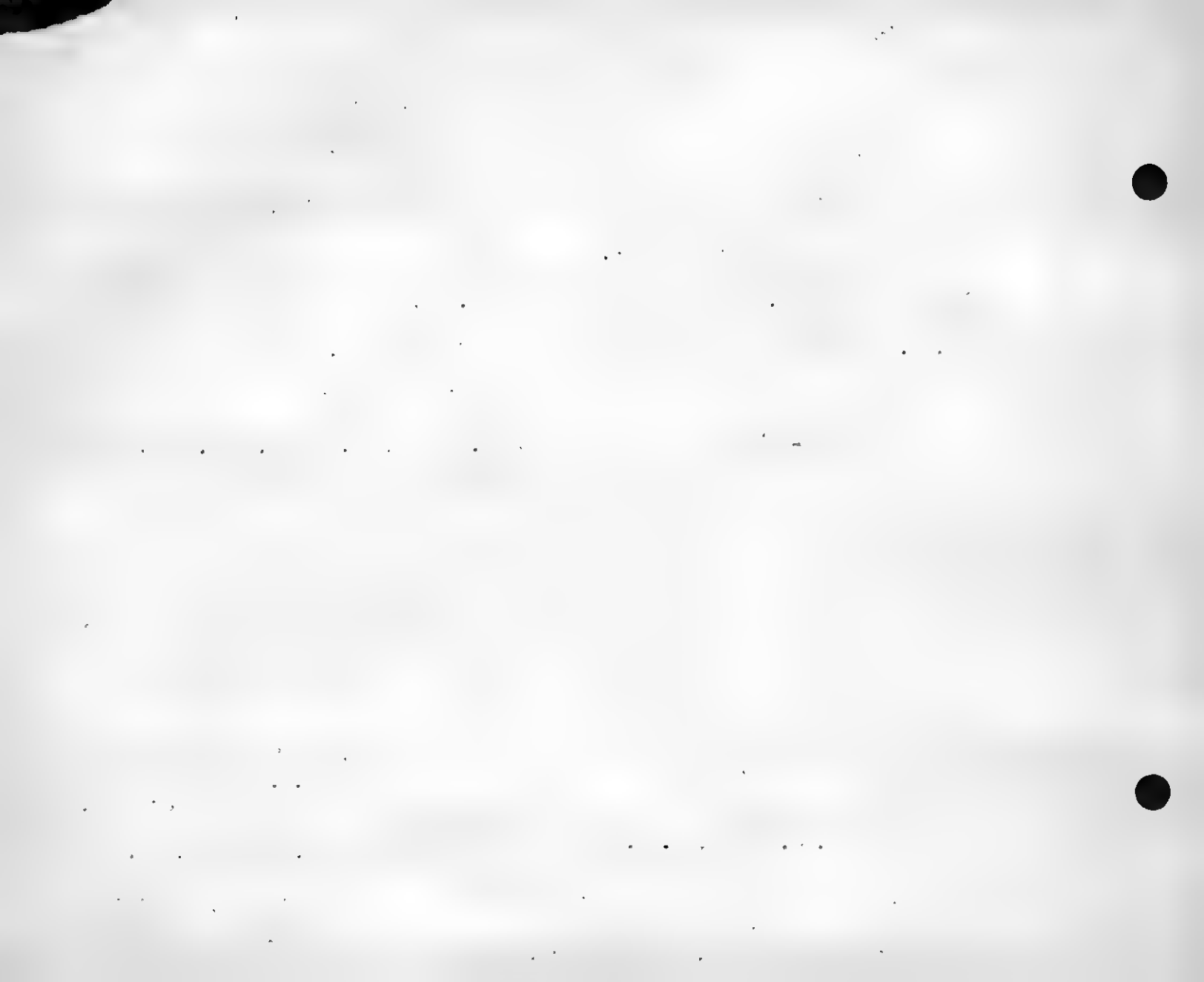
CERTIFICATE OF DEATH

3895

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residente before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 42 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 2003 Glen Drive, Belle Haven	
3. NAME OF DECEASED (Type or print) First Ieland Middle P. Last LOVETTE		4. DATE OF DEATH Month July Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1897
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Greeneville, Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar Byrd Lovette		14. MOTHER'S MAIDEN NAME Lillie Fowler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) Yes 1917-1949		16. SOCIAL SECURITY NO.	
17. INFORMANT Tennessee		Address Capt. Wendell F. Kline, USN, Ret. Sewanee	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforated duodenal ulcer with peritonitis 5411 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from May 29, 1967 to July 10, 1967 , that (he) (we) lost saw the deceased alive on July 10, 1967 , and that death occurred at 8:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>W. J. Forty</i>		22b. DATE SIGNED July 12, 1967	
22c. PHYSICIAN'S NAME (Type) W. J. FORTY, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-14-1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR'S NAME (Type) Falls Church Funeral Home		25a. REC'D BY REGISTRAR JUL 17 1967	
25b. ADDRESS 1102 West Broad Street, Falls Church, Virginia		25c. SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2. Closed by med. for Dr. [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09804

CERTIFICATE OF DEATH

09803

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>M</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in it <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>				d. STREET ADDRESS <u>8505 Glenview Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>E</u> Last <u>LUTSKY</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-15-27</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADMINISTRATIVE ASST.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABOR DEPT. U.S. GOVT.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>ISIDORE NEWMAN</u>			
14. MOTHER'S MAIDEN NAME <u>LENA BERMAN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WWII</u>			
16. SOCIAL SECURITY NO <u>086-12-5358</u>				17. INFORMANT <u>MORRIS LUTSKY</u> Address <u>8505-6 GLENVIEW, AVE. TAKOMA, PK. MD.</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 530X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured Intracranial Aneurysm</u> (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> , 19 <u>67</u> to <u>7-22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7-22</u> , 19 <u>67</u> , and that death occurred at <u>8 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Dallagato Perez</u>				22b. DATE SIGNED <u>7-23-67</u>		22c. PHYSICIAN'S NAME (Type) <u>M.D.</u>	
22d. ADDRESS <u>10305 7th St Silver Spring, Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>D.C. Lodge</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217-9th St. N.W.</u>				25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

09805

09810

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, cover, and in any event, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN + HOSPITAL</u>		e. STREET ADDRESS <u>737 SILVER SPRING AVE</u>	
3. NAME OF DECEASED (Type or print) <u>GERALD KENNETH MACK</u>		4. DATE OF DEATH <u>7 12 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-98</u> 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - US GOVT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>ROMANEO MACK</u>		14. MOTHER'S MAIDEN NAME <u>EMMA ALLEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO <u>Congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe C.O.F.</u> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Uremia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>July 19 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1967</u> to <u>June 14, 1967</u> that (I) (we) last saw the deceased alive on <u>July 14, 1967</u> , and that death occurred at <u>11:37 PM</u> from causes and on the date stated above			
22a. SIGNATURE <u>Raymond O. West</u>		22b. DATE SIGNED <u>7/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND O. WEST</u>		22d. ADDRESS <u>831 University Blvd E. Scl. Sp. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>JUL 44 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

CERTIFICATE OF DEATH

09811

M 09806

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Vienna	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 48 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 2441 Shennandoah St.	
3 NAME OF DECEASED (Type or print) First Middle Last Daniel Alonzo Mahaffey		4. DATE OF DEATH Month Day Year July 30 1967	
5. SEX M	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 March 1926
9. AGE (In years lost birthday) 41 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 17 March 1926	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) KINGS MOUNTAIN, N.C.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Sidney C. Mahaffey		14 MOTHER'S MAIDEN NAME Lucille Gilliam	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II- Korean		16 SOCIAL SECURITY NO 247 32 6538	
17. INFORMANT Joyce Mahaffey		Address 2441 Shennandoah Street Vienna, Virginia	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hodgkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12 June , 19 67 , to 30 July , 19 67 , that (X) (we) last saw the deceased alive on 30 July , 19 67 , and that death occurred at 10:08 PM , from causes and on the date stated above			
22a SIGNATURE <i>J. B. Emery, M.D.</i>		22b DATE SIGNED 31 July, 1967	
22c PHYSICIAN'S NAME (Type) J. B. Emery, M.D.		22d ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b DATE THEREOF 8/3/67	23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d LOCATION (City or Town) (County) (State) Arlington, Virginia
24 FUNERAL DIRECTOR Money and King, Maple Avenue, Vienna Virginia <i>Wm. C. C. C. C.</i>		25a REC'D BY REGISTRAR DATE AUG 7 1967	25b REGISTRAR'S SIGNATURE <i>Charles J. J.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>		d. STREET ADDRESS <u>W. MARKET ST.</u>	
3 NAME OF DECEASED (Type or print) <u>MARIE</u> <u>EMMA</u> <u>MAI</u>		4 DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-16-88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reservation Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	9. AGE (In years lost birthday) yrs <u>79</u>
11 BIRTHPLACE (County & State or foreign country) <u>Delaware</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>CHARLES F. MAI</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MARIE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>L</u>		16 SOCIAL SECURITY NO. <u>181-07-6720-A</u>	
17 INFORMANT <u>CHARLES MAI</u>		Address <u>50 HAWKES BURY LANE SILVER SPRING, MD</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 YRS.</u> <u>30 YRS.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome secondary to cerebral arteriosclerosis</u>			
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or II or both) <u>arteriosclerosis</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from <u>6-5, 1967</u> , to <u>7-30, 1967</u> , that (we) last saw the deceased alive on <u>7-30, 1967</u> , and that death occurred at <u>7:00 PM</u> on causes and on the date stated above.			
22a SIGNATURE <u>Donald W. Datlow, M.D.</u>		22b DATE SIGNED <u>7-30-67</u>	
22c PHYSICIAN'S NAME (Type) <u>DONALD W. DATLOW, M.D.</u>		22d ADDRESS <u>823 UNIV. BLVD WEST SILVER SPRING, MD.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>8-3-1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>ST. JOHNSTOWN Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>GREENWOOD DEL.</u>
24 FUNERAL DIRECTOR <u>William Haiscland</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Greenwood Del</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

DATE AUG 3 1967

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

09808

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09813

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN IT <u>Years.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 E. Montgomery Ave. Apt #2</u>		d. STREET ADDRESS <u>24 E Montgomery Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ruby</u> First <u>H.</u> Middle <u>MANTER</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 6 1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Psychologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind. St. Dept Health</u>	
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		2. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Walter H. Manter</u>		14. MOTHER'S MAIDEN NAME <u>Cora Elledge</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-2122</u>	
17. INFORMANT <u>Mrs Holland Wheeler</u>		6010 Oak Street address <u>Kansas St., Mo.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiac dilatation</u> DUE TO (b) <u>Secondary anemia</u> DUE TO (c) <u>Myelofibrosis of bone marrow</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 years</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Hot While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>7/28/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Bur-Transit</u>		23b. DATE THEREOF <u>8/1/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Laurence, Missouri</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>		25a. REC'D BY REG STRAR <u>AUG 2 1967</u>	
25b. REG. STRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

Rockville, Maryland



3814

09809

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the nonpapers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>Rt #2 Box 352</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Elizabeth S Mason</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/02</u> 9. AGE (In years last birthday) <u>64</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Ind. Mont. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Zachariah Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Luzanna Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Rt 1 Gaithersburg Md -</u>		Address <u>Queen Lillian Newman</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u> DUE TO (b) <u>acc</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>lost</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Jay R Sharpe</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BROOKE GROVE CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>LAYTONSVILLE, MONTG. MD.</u>
24. FUNERAL DIRECTOR <u>Berge R. Snowden</u>		25a. RECEIVED BY REGISTRAR <u>Rockville Md</u> 25b. REGISTERED JUDGE <u>Judge</u>	
25c. DATE <u>JUL 6 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY COUNTY											
1 PLACE OF DEATH a COUNTY Montgomery MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c LENGTH OF STAY IN 1b 2 1/2 mo.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home for the Aged, Inc.						d. STREET ADDRESS 4506 Avondale St.				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Freme Last Mathieson						4. DATE OF DEATH Month July Day 27 Year 1967					
5 SEX F		6 COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH April 6, 1884		9 AGE (In years last birthday) yrs 83		IF UNDER 1 YEAR Months 0 Days 27 Hours 0 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Glasgow, Scotland				12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Alexander Freme						14 MOTHER'S MAIDEN NAME Annie Brown					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16 SOCIAL SECURITY NO 579-03-3882D		17 INFORMANT Asbury Methodist Home, Gaithersburg, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 332x IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21 I certify that (I) (this hospital) attended the deceased from 5/16/67 , 19 to 7/27/67 , that (I) (we) last saw the deceased alive on 7/26/67 , and that death occurred at 7:50 AM , from causes and on the date stated above.											
22a. SIGNATURE Henry C. Scruggs, M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 7/27/67			
22c. PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS, M.D.						22d. ADDRESS &" 7720 Wisconsin Ave., Bethesda					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		July 29, 1967		ROCK CREEK CEMETERY		Washington, D.C.					
25a REC'D BY REGISTRAR ROBERT A. PUMPHREY						25b REGISTRAR'S SIGNATURE BETHESDA, MARYLAND		25c DATE AUG 1 1967			

09811

CERTIFICATE OF DEATH

G9816

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 5 yrs.		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6048 Avon Dr.,				e. STREET ADDRESS 6048 Avon Dr., f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN J. McDONALD			4 DATE OF DEATH Month JULY Day 22 Year 19 67		
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 26, 1915		9 AGE (In years last birthday) 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11 BIRTHPLACE (County & State, or foreign country) Billings, Montana	
13 FATHER'S NAME JOSEPH W. McDONALD			14 MOTHER'S MAIDEN NAME AGNES G. GILSKEY		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16 SOCIAL SECURITY NO 578-30-5149		17 INFORMANT Brother -8126 Old Georgetown Rd. DONALD S. McDONALD (Bethesda, Md.)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO Carcinoma of the Lung DUE TO Carcinoma of Urinary Bladder Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost					INTERVA. BETWEEN ONSET AND DEATH 2 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 5-9- , 19 67 , to 7-22- , 19 67 , that (I) (we) last saw the deceased alive on 7-22- 1967, and that death occurred at 11:45 PM , from causes and on the date stated above.					
22a. SIGNATURE Ronald Barr		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-23-67	
22c. PHYSICIAN'S NAME (Type) DR. RONALD BARR		22d. ADDRESS 10401 Old Georgetown Rd., Bethesda			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF July 25, 1967		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
23d. LOCATION (City or Town) (County) (State) Rockville, Maryland					
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS BETHESDA, MD.		25a. REC'D BY REGISTRAR DATE JUL 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY COUNTY, MARYLAND											
1 PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Md b. COUNTY Pro Geo					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tokoma Park, Md				c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wash Sanitarium and Hospital						d. STREET ADDRESS 5901 Natasha Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Jessie N McKey						4 DATE OF DEATH Month July Day 12 Year 19 67					
5 SEX male		6. COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Dec 4, 1892		9 AGE (In years last birthday) yrs 74		F UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11 BIRTHPLACE (County & State, or foreign country) North Carolina			12 CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Luke W McKoy						14. MOTHER'S MAIDEN NAME Annie L Taylor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 240 26 6737		17. INFORMANT Linwood W Mchoy Beltsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Cirrhosis; Cholangitis DUE TO (c) Intrahepatic Biliary Stasis										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastric Ulcers, Hemorrhagic											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/30 , 19 67 , to 7/12 , 19 67 that (I) (we) last saw the deceased alive on 7/12 , 19 67 , and that death occurred at M , from causes and on the date stated above.											
22a. SIGNATURE Joseph E. Smith Jr.						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/13/67			
22c. PHYSICIAN'S NAME (Type) Joseph E. Smith, Jr. M.D.						22d. ADDRESS Burtonsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 15, 1967		23c. NAME OF CEMETERY OR ADDRESS Ft Lincoln Cemetery				23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24 FUNERAL DIRECTOR F Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR JUL 17 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any. If necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09813

1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 15 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospice, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring Wheaton
d. STREET ADDRESS 11722 Grandview Avenue

3. NAME OF DECEASED (Type or print)
First Rosa Middle Taylor Last Medeiros

4. SEX Male

5. COLOR OR RACE Cauc.

6. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

7. DATE OF BIRTH 9-5-63

8. AGE (In years last birthday) 4 yrs. 7 months 30 days 1967

9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Medeiros

14. MOTHER'S MAIDEN NAME Joan Luckett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT Frank Medeiros Address 11722 Grandview Avenue Silver Spring, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Respiratory failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dislocation of neck between C₁ and C₂
DUE TO (c) Fall and hitting chin

INTERVAL BETWEEN ONSET AND DEATH
40 min.
40 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. Fell 10 ft. off a porch

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 3:00 p.m. 7/30/67

20d. INJURY OCCURRED While ☐ Not While ☒ el work el work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home

20f. (City or town) (County) (State) Silver Spring, Mont., Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from. Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 7/30/67

ACTUAL SIGNATURE John S. Rogers, M.D.

EXAMINER'S NAME (Type) 1919 Seminary Rd., Sil. Srp., Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF August 2, 1967

22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery

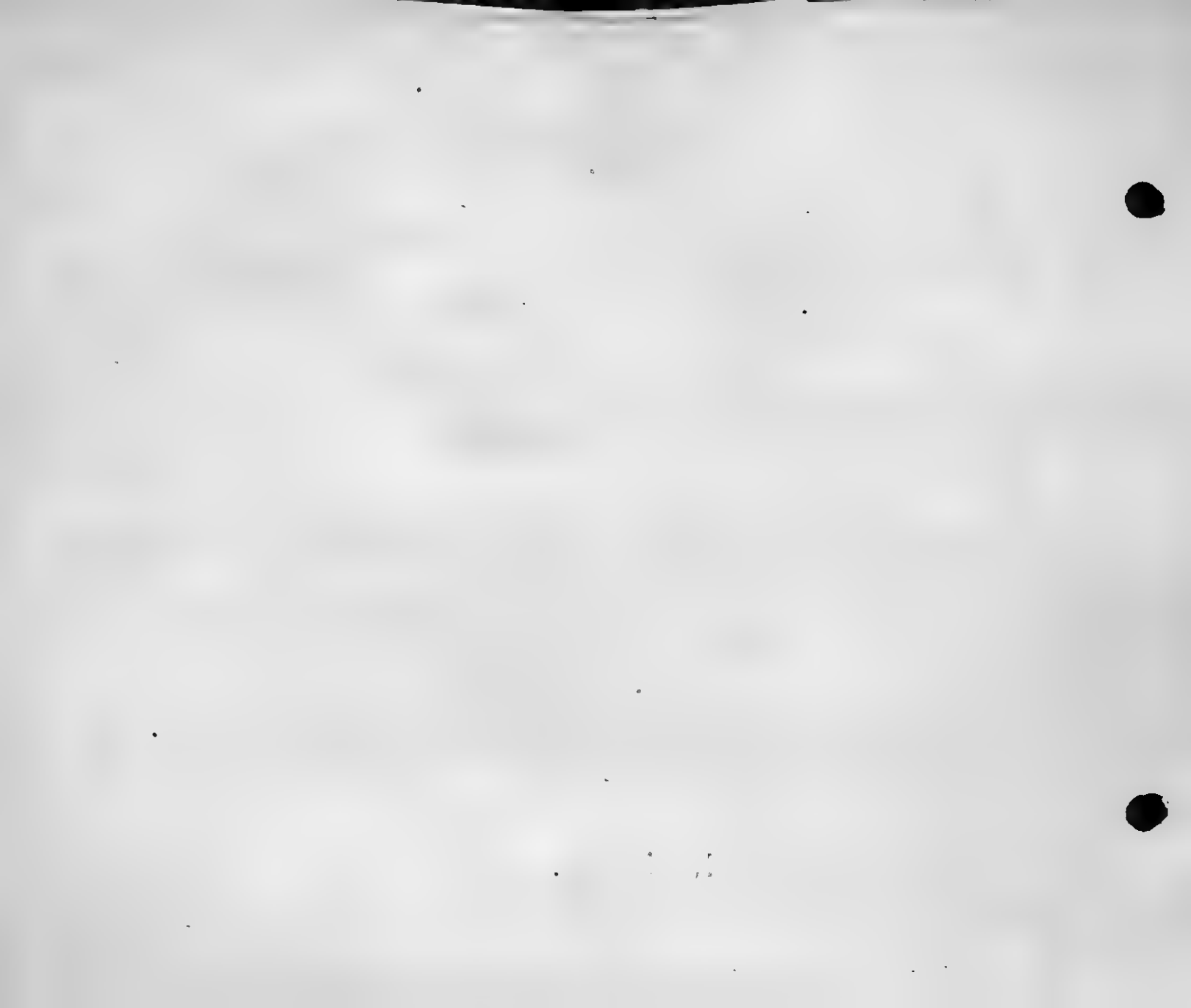
22d. LOCATION (City, town, or country) (State) Prince Georges Co., Maryland

23. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. ADDRESS 313 Georgia Avenue Silver Spring, Md.

24a. REC'D BY REGISTRAR Charles Judge

24b. REGISTRAR'S SIGNATURE Charles Judge

DATE AUG 1 1967



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c LENGTH OF STAY in 1b <u>5 yrs</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4312 Frankfort Dr.</u>		d STREET ADDRESS <u>4312 Frankfort Dr.</u>	
3 NAME OF DECEASED (Type or print) <u>ALLAN LEONARD MENDELSON</u>		4 DATE OF DEATH <u>July 19 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 9, 1932</u> 34 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>		10b K IND OF B-BUSINESS OR INDUSTRY <u>LEGAL</u>	
11 BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>BENJAMIN L. MENDELSON</u>		14 MOTHER'S MAIDEN NAME <u>TESS WEITZ</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service)		16 SOC. SEC. SECURITY NO. <u>578-42-4426</u>	
17 INFORMANT <u>FATHER</u>		Address <u>9039 Sligo Creek Rd. Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gunshot wound through head, apparently self-inflicted.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>head, apparently self-</u> (c) <u>inflicted.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased depressed shot self in head with automatic pistol.</u>	
20c TIME OF INJURY Month, Day, Year <u>5:45 pm 7-19-1967</u>		20d PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not while at work		20f CITY OR TOWN (County) (State) <u>Rockville Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>7-19-1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7/21/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u>	23d LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u>
24 FUNERAL HOME <u>M. Stein Hebrew Memorial Funeral Home</u>		25a REC'D BY REGISTRAR <u>JUL 24 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

00815

CERTIFICATE OF DEATH

00820

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Virginia b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Bethesda		c LENGTH OF STAY IN Tb 7 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Bethesda, Md.		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) John Albert MEROTH		4. DATE OF DEATH Month July Day 2 Year 1967	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6 Jul 1911
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. ARMY (retired)		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs 55
11 BIRTHPLACE (County & State, or foreign country) New Haven, Conn.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Albert MEROTH		14. MOTHER'S MAIDEN NAME Helen HANSMAN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 10-2-42 to 1-30-63		16 SOCIAL SECURITY NO 045 03 8800	
17. INFORMANT Mrs. Simone M. MEROTH		Address Box 77 King George, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, right lung with Metastasis 165A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 26 Jun, 1967, to 2 Jul, 1967, that (I) (we) last saw the deceased alive on 2 Jul, 1967, and that death occurred at 5:53 AM, from causes and on the date stated above.			
22a. SIGNATURE W. J. FOOTY		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) W. J. FOOTY, CDR MC USN		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 7-3-67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	23d. LOCATION (City or Town) (County) (State) SUITLAND Md.
24. FUNERAL DIRECTOR IVES FUNERAL HOME, ARLINGTON, VA.		25a. RECEIVED BY STRA... DATE JUL 6 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09816

CERTIFICATE OF DEATH

09821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>Rt 3 Box 178</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Michael</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1967</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	9. AGE (In years last birthday) yrs <u>2</u> Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Murlen Miller</u>		14. MOTHER'S MAIDEN NAME <u>Margie Ellen Darner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>-----</u>	17. INFORMANT <u>Father</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>776A</u> IMMEDIATE CAUSE (a) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>41 hrs.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital), attended the deceased from <u>July 10, 1967</u> to <u>July 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1967</u> , and that death occurred at <u>5:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Ralph Stiller</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Ralph Stiller M.D.</u>		22d. ADDRESS <u>1111 Spring Street S.S.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Rockville, Md.</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

CERTIFICATE OF DEATH

00822

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 47 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Salvatore Middle (NMN) Last Millone		4. DATE OF DEATH Month July Day 5 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1915 9. AGE (In years last birthday) 52 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Tile Setter		10b. KIND OF BUSINESS OR INDUSTRY Tile	11. BIRTHPLACE (County & State, or foreign country) Italy
13. FATHER'S NAME Stefano Millone		14. MOTHER'S MAIDEN NAME Leonarda Rapisardi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) No		16. SOCIAL SECURITY NO. 214-34-6828	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia and purulent meningitis DUE TO (b) Metastatic carcinoma of the lung DUE TO (c) Urinary tract infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary tract infection			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 19 , 19 67 , to July 5 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 5 , 19 67 , and that death occurred at 6:25 M, from causes and on the date stated above.			
22a. SIGNATURE CM Haskell		22b. DATE SIGNED 5 July 1967	
22c. PHYSICIAN'S NAME (Type) Charles M. Haskell, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7 JULY 1967	23c. NAME OF CEMETERY OR CREMATORY CATHOLIC HEAVEN	23d. LOCATION (City or town) (County) (State) SILVER SPRING MD.
24. FUNERAL DIRECTOR Rinaldi Funeral Home, Inc. 7400 GEORGIA AVE. N.W.		25a. REC'D BY REGISTRAR JUL 7 1967	25b. REGISTRAR'S SIGNATURE Charles J. J...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11 Chestnut Street</u>		d. STREET ADDRESS <u>11 Chestnut Street</u>	
3 NAME OF DECEASED (Type or print) <u>Nettie</u>		4 DATE OF DEATH Month <u>July</u> - Day <u>14</u> - Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 15, 1892</u>
9 AGE (In years lost birthday) <u>74</u> yes		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Bradley Norwood</u>		14 MOTHER'S MAIDEN NAME <u>Margaret Trail</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. <u>577-32-7420</u>	
17 INFORMANT <u>Thomas Norwood</u>		Address <u>1018 Scott Ave Rockville, Md</u>	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Chronic Leukemia</u> (c) <u>1044</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>7/15/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parish Lawn</u>	23d. LOCATION (City or town) (County) (State) <u>Rockville Montg. Md.</u>
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REG. STRAR <u>JUL 19 1967</u>	25b. REG. STRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09810

CERTIFICATE OF DEATH

09824

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>3807 Inverness Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Sylvia</u> First <u>Stevens</u> Middle <u>Moore</u> Last		4. DATE OF DEATH <u>July</u> Month <u>23</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-05</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. FUND 1 Year <u>23</u> Months <u>23</u> Days <u>19</u> Hours <u>67</u> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Chicago Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert W. Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Husband of 3807 Inverness Dr.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>Emphysema</u> DUE TO (c) <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u>None</u>	
20c. TIME OF INJURY Month, Day Year Hour o m p m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>7/21</u> , 19 <u>67</u> , to <u>privat</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>7/21</u> , 19 <u>67</u> , and that death occurred at <u>8:00</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umhau</u>		22b. DATE SIGNED <u>7/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>		22d. ADDRESS <u>8805 CONN. AVE CHEVY CHASE</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>7-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09820		09825	
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>27 days</u>		d. STREET ADDRESS <u>5509 Sonoma Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ludman</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Clifford L. Morrison</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>m.</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-6-96</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Teller</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Bethesda Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James L.</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Bogley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>220-28-5805</u>	
17 INFORMANT <u>Elizabeth M. Umbholtz</u>		Address <u>2308 S. Lincoln Ave. Silver Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Chronic G.U. Tract Infection</u> DUE TO (c) <u>1954</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5/22/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>58</u> to <u>7/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/6</u> , 19 <u>67</u> , and that death occurred at <u>10 p.m.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Clifford L. Morrison</u>		22b. DATE SIGNED <u>7/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. J. BRENNAN</u>		22d. ADDRESS <u>Cherry Chase Rd</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	23b. DATE THEREOF <u>7-10-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>	
ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1000

1000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09326

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b <u>12 hours</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>901 Chillum Court</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jean Esther Mowrey</u>		4. DATE OF DEATH <u>7-31-67</u>		19. MONTH <u>19</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>32</u> yrs	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>		10. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Raymond McFerren</u>				14. MOTHER'S MAIDEN NAME <u>Ollie Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>579-48-4232</u>		17. INFORMANT <u>Patent's chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diffuse Subarachnoid Hemorrhage</u> DUE TO (b) <u>Hemorrhage</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Rapp</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. RAPP M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8/3/67</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Meo, Park</u>				23d. LOCATION (City or town) (County) (State) <u>Prince George, Md.</u>			
24. FUNERAL DIRECTOR <u>Lowe's Funeral Home</u>				25. DATE BY WHICH THIS CERTIFICATE SHOULD BE FILED <u>AUG 2 1967</u>			
ADDRESS <u>1425 Md. Ave. N. E. D. C.</u>				25b. SIGNATURE <u>[Signature]</u>			



09822

CERTIFICATE OF DEATH

09822

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland - Rural c. LENGTH OF STAY IN lb 15.1		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 801 Seeks Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) TERESA First E. MULLICAN Middle Last		4. DATE OF DEATH Month July Day 4 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 7, 1882 9 AGE (in years last birthday) 85 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Schultz		14 MOTHER'S MAIDEN NAME Catherine Dean	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-48-0968	
17 INFORMANT F. Dean Mullican-Item # 2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 0531 Staphylococcal Septicemia IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 65 , to 7/4 , 19 67 , that (I) (we) last saw the deceased alive on 7/4 , 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above.			
22a SIGNATURE Norman H. Rubenstein		22b. DATE SIGNED 7/4/67	
22c. PHYSICIAN'S NAME (Type) Norman H. Rubenstein		22d. ADDRESS 359 Scott Dr., Silver Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/6/67	23c. NAME OF CEMETERY OR CREMATORY Colesville Meth. Ch. Cem.	23d. LOCATION (City or Town) (County) (State) Colesville, Md.
24 FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR DATE JUL 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. J...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

99823

CERTIFICATE OF DEATH

99823

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lewisdale		c. LENGTH OF STAY IN 1b Rural- Lewisdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD, Monrovia		d. STREET ADDRESS R.F.D. Monrovia	
3 NAME OF DECEASED (Type or print) First Urner Middle R. Last Mullinix		4 DATE OF DEATH Month July Day 29 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 7, 1890
9 AGE (in years last birthday) 77 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick layer	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lewisdale, Md.	
13. FATHER'S NAME Sherman Mullinix		14. MOTHER'S MAIDEN NAME Annie D. Mullinix	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. 1		16. SOCIAL SECURITY NO. 214-14-4378	
17. INFORMANT Mrs E. Rena Mullinix, Item 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 year ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardiovascular Renal Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No accident involved	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from April 5, 19 67 to July 29, 19 67 , that (I) (we) saw the deceased alive on July 29, 19 67 , and that death occurred at 6:00 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>McKendree Boyer, M.D.</i> M.D.		22b. DATE SIGNED July 30, 1967	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M.D.		22d. ADDRESS 9701 Church Street Damascus, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 31, 1967	23c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.	23d. LOCATION (City or town) _____ (County) _____ (State) _____ Browningsville, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE AUG 1 1967	
		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>	

09824

CERTIFICATE OF DEATH

00829

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		d STREET ADDRESS <u>2918 South 20th Street</u>	
3 NAME OF DECEASED (Type or print) <u>Kathryn Adolphus Mullins</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9 October 1930</u>
9 AGE (In years lost birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Service</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John B. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Juanita Curtis</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>228-42-4604</u>	
17 INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cryptococcal Meningitis</u> DUE TO (b) <u>Hodgkins Disease</u> DUE TO (c) <u> </u>			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the cervix</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour <u> </u> m <u> </u> p.m. <u> </u> 19 <u> </u>		20d INJURY OCCURRED Wh. e <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>21 June</u> , 1967, to <u>1 July</u> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1 July</u> , 1967, and that death occurred at <u>11:10M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dan C. Bird, MD</u>		22b. DATE SIGNED PM M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> <u>2 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dan C. Bird, MD</u>		22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/8/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>South Arlington, Md.</u>	
24. FUNERAL DIRECTOR <u>James E. Bird</u>		25a. REC'D BY REGISTRAR <u>JUL 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09825

CERTIFICATE OF DEATH

09825

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DC b. COUNTY 117	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b April 3 Mo.		d. STREET ADDRESS 4600 - 45th ST NW	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SYLVAN MANOR HEALTH CARE CENTER		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) FRANCES E. MURPHY		4 DATE OF DEATH Month JULY Day 9 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 12 1876
9. AGE (In years last birthday) yrs 91		IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hallgrave		14. MOTHER'S MAIDEN NAME TERESA ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT LAURENCE SPELLBRING		Address DICKERSON, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) -			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jul 3, 1967 to Jul 9, 1967 , that (I) (we) last saw the deceased alive on Jul 8, 1967 , and that death occurred at 9:30 PM from causes and on the date stated above.			
22a. SIGNATURE Robert J. Thibadeau		22b. DATE SIGNED 7-9-67	
22c. PHYSICIAN'S NAME (Type) ROBERT J. THIBADEAU		22d. ADDRESS ROCKVILLE MD 20852	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 12 1967	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR H. Don. DeVol		25a. REC'D BY REGISTRAR JUL 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

09826

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00881

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>WASHINGTON DC</u> b. COUNTY <u>DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHERRY CHASE</u>		c. LENGTH OF STAY IN 15 <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>OCTAGONIA SILVER SPRING HOSPITAL</u>				d. STREET ADDRESS <u>7045 31st ST. NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>CHARLES ELMER MURRAY SR.</u>				4 DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/1896</u>	9. AGE (In years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING BUSINESS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>YES U.S.</u>	
13. FATHER'S NAME <u>WILLIAM MURRAY</u>				14. MOTHER'S MAIDEN NAME <u>GERTRUDE KELLY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>1ST MCHST BATTAL</u>		16. SOCIAL SECURITY NO <u>5 77-10 1898-B</u>		17. INFORMANT <u>Gertrude C. Murray</u> Address <u>WIFE - 5614 Item #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>ASHD.</u> DUE TO (c) <u>Genl. arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>5 yrs.</u> <u>5-7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt had massive stroke mid June 1967.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>19 July 1967</u> , and that death occurred at <u>2 P</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Charles E. Keegan Jr</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>21 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>CHARLES E. KEEGAN JR. MD</u>				22d. ADDRESS <u>3752 Boston St NW WASH DC 20007</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-25-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery Silver Spring Md</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Joseph G. Walters, Son of J. S. Walters</u>				ADDRESS <u>3130 Wisc Ave NW WASH DC</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09822

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE, MARYLAND</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>259 Congressional Ave</u> Apt. 705	
3 NAME OF DECEASED (Type or print) <u>NELLIE BEST NEFF</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 23, 1889</u> 9 AGE (In years last birthday) <u>77</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>HUTCHINSON, KANSAS</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>RICHARD E. ROBERTS</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Best Roberts</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>267461729B</u>	
17 INFORMANT <u>Harold A. Neff-259 Congressional Lane</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c)			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular Disease with Vascular occlusion</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1965</u> to <u>July 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/18</u> 19 <u>67</u> , and that death occurred at <u>9:25 PM, 7/20/67</u> , from causes and on the date stated above			
22a SIGNATURE <u>Max G. Sherer</u>		22b DATE SIGNED <u>7/20/67</u>	
22c PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u>		22d ADDRESS <u>800 Pershing Drive S.E. Sp. Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>7/22/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCAT ON (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Thos. H. Hines Co. Wash. D.C.</u>		25a REC'D BY REGISTRAR <u>JUL 24 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

00825

CERTIFICATE OF DEATH

00023

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Carlos F. Noyes</u>		4 DATE OF DEATH <u>July 2 1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>9-18-1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Controller of Baltimore</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Franklin F. Noyes</u>		14. MOTHER'S M maiden name <u>Harriet Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>16 3-09-4907</u>	
17 INFORMANT <u>Admission Discharge Record</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u>		b. <u>Arteriosclerotic Heart Disease</u>	
c. <u>Abdominal aortic aneurysm</u>		d. <u>Esophageal achalasia</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis & emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1964</u> to <u>July 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>June 13, 1967</u> , and that death occurred at <u>7 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Albert H. O'Rollman, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. O'ROLLMAN, MD</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>7-3-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Southland Prince Georges Md</u>	
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey F.H.</u>		25a. REC'D BY REGISTRAR <u>JUL 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

Reviewed and signed by Medical Examiner: [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

09829

09829

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN lb 25 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 483 Chinlee Drive	
3 NAME OF DECEASED (Type or print) James O'CONNOR, JR.		4 DATE OF DEATH Month July Day 10 Year 19 67	
5 SEX Male	6 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1935
9 AGE (n years last birthday) yrs 32		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Orange, New Jersey		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Francis O'Connor		14. MOTHER'S MAIDEN NAME Dorothy Egan	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1955-1966		16 SOCIAL SECURITY NO. 144-26-9900	
17 INFORMANT Mrs. Arlene O'Connor, 483 Chinlee Drive		Address New Jersey	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Embryonal Carcinoma right testicle with multiple metastases. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 15, 1967 to July 10, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on July 10, 1967 , and that death occurred at 6:20 PM , from causes and on the date stated above.			
22a SIGNATURE <i>P. B. Blanchard</i>		22b DATE SIGNED 12 July 1967	
22c PHYSICIAN'S NAME (Type) P. B. Blanchard, M. D.		22d ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial-transit	7-17-67	Arlington Natl Cem.	Arlington, Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		25a REC'D BY REGISTRAR JUL 19 1967	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the document is a list of the names of the persons who were present at the meeting. The names are listed in alphabetical order.

2. The second part of the document is a list of the names of the persons who were present at the meeting. The names are listed in alphabetical order.

3. The third part of the document is a list of the names of the persons who were present at the meeting. The names are listed in alphabetical order.

CERTIFICATE OF DEATH

09830

09824

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. REAP, MED. EXAM., NOTIFIED AND APPROVED. JGS.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4701 Willard Avenue		d. STREET ADDRESS 4701 Willard Avenue	
3. NAME OF DECEASED (Type or print) RUTH ELIZABETH OCHS		4. DATE OF DEATH Month JULY Day 23 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-1903
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 10 Days 23 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adolph Volk		14. MOTHER'S MAIDEN NAME Mamie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-60-0352	
17. INFORMANT Karl W. Ochs-See Item #2.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis. DUE TO 1972 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1972 (c) 1972			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from July 18, 1966 to July 23, 1967 , that (2) (we) last saw the deceased alive on July 18, 1967 , and that death occurred at 7:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE James R. Coleman M.D.		22b. DATE SIGNED July 23, 1967	
22c. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN		22d. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-26-1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Md.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.		25. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

33831
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

836

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>714 Harrington Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy O'Dell</u>		4. DATE OF DEATH <u>July 4 1967</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1947</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years last birthday) <u>19</u> IF UNDER 1 YEAR: Months <u>5</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u>5</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jack Walter O'Dell</u>		14. MOTHER'S MAIDEN NAME <u>Opheelia Rodriguez Perez</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Jack Walter O'Dell</u>	
17. INFORMANT <u>Jack Walter O'Dell</u>		Address <u>714 Harrington Rd. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uterectasis, Premature</u> DUE TO (b) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BL RELATED TO THE TERMINAL DISEASE CONDITION - IN PART I(a), 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs 20 min</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY CURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/4 1967</u> to <u>7/4 1967</u> that (I) (we) last saw the deceased alive on <u>7/4 1967</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Feoli MA</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Feoli</u>		22d. ADDRESS <u>11125 ROCKVILLE PIKE ROCKVILLE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/6/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

09832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0377

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not in an institution; Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c LENGTH OF STAY IN 1b <u>Approx</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS <u>Cat tail Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence L. Owens</u>		4. DATE OF DEATH <u>July 30</u> 19 <u>67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24 1899</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
14. FATHER'S NAME <u>Samuel L. Owens</u>		15. MOTHER'S MAIDEN NAME <u>Sally Kai</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. SOCIAL SECURITY NO	
18. INFORMANT		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> DUE TO (b) <u>Mural thrombosis Rt. atrium</u> DUE TO (c) <u>last</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>73067</u>
EXAMINER'S NAME (Type) <u>John S. Rogers</u>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elizah Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Poolesville Montgomery Md</u>
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>		25a. REC'D BY REGISTRAR <u>AUG 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove design papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

C. Dep. med. exam. M. Resp. injured + cleared by M. Resp. J.R.C.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15.1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>713 CHESAPEAKE AVE</u>						d. STREET ADDRESS <u>713 CHESAPEAKE AVE</u>					
3. NAME OF DECEASED (Type or print) <u>GEORGE L OWENS</u>						4. DATE OF DEATH <u>JULY 21 1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1900</u>		9. AGE (In years last birthday) <u>66 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST HELPER</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Page County, VA</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Charles D OWENS</u>						14. MOTHER'S MAIDEN NAME <u>Julia BURACKER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u>						16. SOCIAL SECURITY NO. <u>WARD OWENS</u>					
17. INFORMANT <u>WARD OWENS</u>						Address <u>Stanley, VA.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u>											
DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> 10 yrs.											
DUE TO (c) <u>Chronic Pulmonary emphysema</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary emphysema</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <u>Sept. 1964</u> to <u>July 21, 1967</u> , that (1) (we) last saw the deceased alive on <u>July 10, 1967</u> , and that death occurred at <u>7:21 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James R. Coleman M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 21, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>						22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>7/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GRAVES Chapel</u>		23d. LOCATION (City, town or county) (State) <u>Stanley, VA</u>			
24. FUNERAL DIRECTOR <u>Arthur Walters</u>						25a. REC'D BY REGISTRAR <u>JUL 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09834

09839

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 39 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS Quarters 2965-A	
3. NAME OF DECEASED (Type or print) Connie Sue PACK		4. DATE OF DEATH Month July Day 7 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1967
9. AGE (in years last birthday) yrs 96		IF UNDER 1 YEAR Months 96 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Quantico, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wallace L. Pack		14. MOTHER'S MAIDEN NAME Lillian Killinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO N/A	
17. INFORMANT Quantico		Address Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Letterer-Siwe's Disease DUE TO 2021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 21 (this hospital) attended the deceased from May 29 , 19 67 , to July 7 , 19 67 , that 21 (we) last saw the deceased alive on July 7 , 19 67 , and that death occurred at 430A M, from causes on and on the date stated above			
22a. SIGNATURE Jerry J. Tomasovic		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-11-67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR JUL 13 1967	
Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles J. Jones	



09835

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. LENGTH OF STAY IN TB <u>2 1/2 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery Cancer Nursing Home</u>		e. STREET ADDRESS <u>2902 Sheraton St.</u> <u>2444/11/13/14/15/17/11/18</u>	
3 NAME OF DECEASED (Type or print) <u>Jessie Ross Parcoast</u>		4. DATE OF DEATH Month <u>7</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1874</u>
9. AGE (In years last birthday) <u>93</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>24</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gen. Nathan Ross</u>		14. MOTHER'S MAIDEN NAME <u>Burgess</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-54-7375 E</u>	
17. INFORMANT <u>Mr Ross Parcoast</u>		Address <u>27 Sheraton St. Silver Spring, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm Accident</u> DUE TO (b) <u>Thrombolytic occlusion</u> DUE TO (c) <u>arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-24</u> , 19 <u>56</u> , to <u>7-21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-21</u> , 19 <u>67</u> , and that death occurred at <u>11:00 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John S. Rogers, MD</u>		22b. DATE SIGNED <u>7-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John S. Rogers, MD</u>		22d. ADDRESS <u>1918 Semin 2nd Rd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/25/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harford Ad Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Harford MD Baltimore</u>	
24 FUNERAL DIRECTOR <u>W.W. Chomare Co.</u>		25a. REC'D BY REGISTRAR <u>W.W. Chomare Co.</u>	
25b. ADDRESS <u>1400 Chapin St. Washington, D.C.</u>		25c. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09836

CERTIFICATE OF DEATH

09841

1. PLACE OF DEATH a. COUNTY MON. GOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MON. GOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, RURAL		c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GIEVY CHASE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL			d. STREET ADDRESS 3317 W. COQUELIN TERR.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CATHERINE Middle COCKRILLE Last PANKLEY			4. DATE OF DEATH Month JULY Day 24 Year 19 67		
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 8, 1914		9. AGE (In years last birthday) 53 yrs IF UNDER 1 YEAR: Months 24 Days 19 Hours 67 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State or foreign country) WASHINGTON, D.C.	
13. FATHER'S NAME Clarence COCKRILLE			14. MOTHER'S MAIDEN NAME Rosa Lee Groves		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RUSSELL G. PANKLEY Address CHASE, MD. 3317 W. COQUELIN TERR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE CERVIX (EPIDERMOID) DUE TO (b) 171A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 171A					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) US NAVAL HOSPITAL, BETHESDA, MD.	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from JULY 21, 19 67 to JULY 24, 19 67 that (I) (we) last saw the deceased alive on JULY 24, 19 67 , and that death occurred at 4:40 PM , from causes and on the date stated above.					
22a. SIGNATURE Neil D. Jackson		22b. DATE SIGNED 7/24/67		22c. PHYSICIAN'S NAME (Type) NEIL D. JACKSON	
23a. BURIAL CREMATION, REMOVAL (State)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L CEMETERY	
23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.					
24. FUNERAL DIRECTOR Joseph Gawler & Sons Funeral Home 5130 Wisconsin Ave., N.W. Washington, D.C.			25a. REC'D BY REGISTRAR JUL 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 4011 Bradley Lane	
3 NAME OF DECEASED (Type or print) GLORIA C. PARANAGUA		4 DATE OF DEATH Month JULY Day 8 Year 1967	
5 SEX Female	6 COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/30/97
9. AGE (In years last birthday) 69 yrs		IF UNDER 1 YEAR Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) North Wales		12 CITIZEN OF WHAT COUNTRY United Kingdom	
13 FATHER'S NAME Guy Herbert Wood		14 MOTHER'S MAIDEN NAME Ethel Murial Brough	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-46-5594	
17. INFORMANT (friend) Mrs. R.L. Kearney		Address Wash., D.C. 3426 16th St., N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Breast Carcinoma DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 mo 5 yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAY 1967 to 7/8 , 1967 that (I) (we) lost saw the deceased alive on 7/7 , 1967, and that death occurred at 6 PM , from causes and on the date stated above.			
22a SIGNATURE Andrew J. Brennan, M.D.		22b. DATE SIGNED 7/8/67	
22c PHYSICIAN'S NAME (Type) Andrew J. Brennan, M.D.		22d ADDRESS Chevy Chase, Md	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 7/11/67	23c NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	23d LOCATION (City or Town) (County) (State) Waynesboro, Pa.
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc. Washington, D.C.		25a. REC'D BY REGISTRAR JUL 13 1967	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00843

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event with in 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY N 16 <u>1 HR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>METROPOLITAN DRIVE RD</u>	
3 NAME OF DECEASED (Type or print) <u>MAURICE WILBERT PARIS</u>		4 DATE OF DEATH <u>JULY 25 1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/27/1914</u>
9 AGE (In years last birthday) <u>52</u> yrs		10 IF UNDER 24 HRS Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Messenger U.S. Gov</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>CHARLES PARIS</u>		14 MOTHER'S MAIDEN NAME <u>Wife Anna Paris</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes ARMY</u>		16 SOCIAL SECURITY NO <u>Wife Anna Paris</u>	
17 INFORMANT <u>Wife Anna Paris</u>		Address <u>Same as above</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis. Acute.</u> DUE TO (b) <u>Cardiovascular Disease -</u> DUE TO (c) <u>Years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 m</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>7/25/67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>July 29 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>West X. Brown</u>		ADDRESS <u>Richfield, Md.</u>	
25a. REC'D BY REGISTRAR <u>JUL 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09839

CERTIFICATE OF DEATH

0344

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3wks 3days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General		d. STREET ADDRESS 3632 Gleneagles Dr., Apt 8G2	
3. NAME OF DECEASED (Type or print) First Adah Middle Florence Last Patterson		4. DATE OF DEATH Month July Day 12 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-91
9. AGE (in years lost birthday) 76 yrs		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Otto		14. MOTHER'S MAIDEN NAME Emma Edgar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-34-85778	
17. INFORMANT Homer L Patterson 9700 Dyer St., El Paso, Texas		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pulmonary Congestion DUE TO (b) Rt. Heart Failure DUE TO (c) Metastatic Ca of Liver, Primary site undetermined PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Refractory Anemia	
19. INTERVAL BETWEEN ONSET AND DEATH hours		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 17 , 19 67 , to July 12 , 19 67 , that (I) (we) last saw the deceased alive on July 12 , 19 67 , and that death occurred 2:26A M, from causes and on the date stated above.			
22a. SIGNATURE Richard A. Yates		22b. DATE SIGNED 7/12/67	
22c. PHYSICIAN'S NAME (Type) Richard A. Yates		22d. ADDRESS Old Baltimore Rd., Olney, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/15/67	
23c. NAME OF CEMETERY OR CREMATORY George Washington		23d. LOCATION (City or Town) (County) (State) Riggs Rd. Adelphi, Md.	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md.		25a. REC'D BY REGISTRAR Charles Jones	
25b. REGISTRAR'S SIGNATURE Charles Jones		DATE JUL 14 1967	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09840

09845

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admiss on) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>		d. STREET ADDRESS <u>7805 Accotink Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Alma</u> Last <u>Perry</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-01</u>
9. AGE (In years lost birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.Va</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ransom Lovins</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Jessups</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>578-30-9832</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u>			
DUE TO (b) <u>Acute myocardial infarction</u>			
DUE TO (c) <u>Infective Cholecystitis Pancreatic abscess</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>11</u> Day <u>16</u> Year <u>1966</u> Hour a.m. <u>11</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/16/66</u> to <u>7/2/67</u> , that (I) (we) last saw the deceased alive on <u>7/2/67</u> , and that death occurred at <u>4:23</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>H. J. Morse</u>		22b. DATE SIGNED <u>7/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. J. Morse MD</u>		22d. ADDRESS <u>7030 Carroll Ave - Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/6/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CAK VALE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>CAK VALE W. Va</u>	
24. FUNERAL DIRECTOR <u>EVERLY-WHEATLEY FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ALEXANDRIA, VA</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>		DATE <u>JUL 7 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

C9846

C9841

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>16 PRIMROSE STREET</u>	
3. NAME OF DECEASED (Type or print) <u>GRACE Auglier Pettin</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/1886</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Auglier</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>Emil Joseph Pettin</u>		Address <u>16 PRIMROSE ST. CACAMID</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, TERMINAL</u> 4501 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>GANGRENE LEFT LOWER EXTREMITY</u> 8 DAYS (c) <u>OBLITERATIVE ARTERIOSCLEROTIC PERIPHERAL VASC. DISEASE</u> 5 YEARS		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ANEURYSM ASCENDING AORTA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 30, 1967</u> , to <u>JULY 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 30, 1967</u> , and that death occurred at <u>3:30A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Robert G. Angle</u>		22b. DATE SIGNED <u>JULY 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G Angle</u>		22d. ADDRESS <u>5009 Del Ray Ave Bethesda, Md</u>	
23a. BURIAL, CREMATION, <u>BURIAL</u>	23b. DATE THEREOF <u>7-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		25. REC'D BY REGISTRAR <u>JUL 6 1967</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25b. REGISTRAR'S ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09842		09847	
1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>17 days</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d STREET ADDRESS <u>617 Elm Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Lloyd H Poynter</u>		4 DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-20-93</u>
9 AGE (In years last b "day) <u>73</u> yrs		IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>67</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Kentucky</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Kentucky</u>		12 CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Thomas Poynter</u>		14 MOTHER'S MAIDEN NAME <u>Emily Payne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I Army</u>		16 SOCIAL SECURITY NO <u>1404-09-6837</u>	
17 INFORMANT <u>Patient's chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> (c) <u>and Pulmonary emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.T ON GIVEN IN PART I(a) <u>Acute Gastric ulcer - Recent hemorrhage</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>7/19</u> , 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>7/18</u> , 19 <u>67</u> , and that death occurred at <u>4:10</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Griswold M.D.</u>		22b DATE SIGNED <u>7/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John D. Griswold M.D.</u>		22d ADDRESS <u>4830 V. St NW, DC</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>7/21/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		23d LOCATION (City or town) (County) (State) <u>BALTIMORE MD.</u>	
24 FUNERAL DIRECTOR <u>GASCH'S</u>		25a REG'D BY REGISTRAR <u>JUL 21 1967</u>	
ADDRESS <u>HYATTSVILLE, MARYLAND</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

09843

09848

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d STREET ADDRESS Box 81	
3 NAME OF DECEASED (Type or print) Bessie Pratt		4 DATE OF DEATH July 18 1967	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8-6-92
9 AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME George Jackson	
14 MOTHER'S MAIDEN NAME Margaret Hopkins		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17 INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive C-V Disease, & Chronic Nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNPREVENTING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour o m p m 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 60 to 7/18/67 , that (I) (we) last saw the deceased alive on 7/17/67 , and that death occurred at 6:15 am from causes and on the date stated above.			
22a SIGNATURE Dr. Charles Ligon		22b DATE SIGNED 7/18/67	
22c PHYSICIAN'S NAME (Type) Dr. Charles Ligon		22d ADDRESS Sandy Spring, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 7/22/67	23c NAME OF CEMETERY OR CREMATORY SANDY SPRING CEMETERY	23d LOCATION (City or Town) (County) (State) SANDY SPRING, MONTG. MD.
24 FUNERAL DIRECTOR Robert L. Snowden		25a REC'D BY REGISTRAR JUL 24 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		25c REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

00844

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>DE.</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
c. LENGTH OF STAY IN 1b <u>1/2 day</u>		d. STREET ADDRESS <u>4000 Cathedral Ave. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Bethesda Silver Spring Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MARGARET BLAKE PURVIS</u>		4 DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cauc</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-5-85</u>
9 AGE (In years lost birthday) <u>82</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supr. Nursing Education</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NURSING</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Water town N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>ARTHUR J. PURVIS</u>		14 MOTHER'S MAIDEN NAME <u>ELLEN BLAKE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16 SOCIAL SECURITY NO. <u>579-60-6431</u>	
17 INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH <u>Many years</u>			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Emphysema + Bronchitis</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>7-3-</u> , 19 <u>67</u> , that (I) <u>was</u> last saw the deceased alive on <u>MAY 30, 1967</u> , and that death occurred at <u>7:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>R.W. Langevin</u>		22b. DATE SIGNED <u>7/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.W. LANGEVIN, MD</u>		22d. ADDRESS <u>1234 19th St. N.W. WASH. D.C.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>RED BANK, N.J.</u>	
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SONS</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Mental Examinations with Women

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09845

09850

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 MONTH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2105 GREENERY LANE APT 302 SILVER SPR. MD.</u>				d. STREET ADDRESS <u>2105 Greenery Lane Apt 302 SS.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>ANDERSON</u> Last <u>QUINLAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 12, 1906</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANDREW Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Signe Pihlo</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>218-56-5544</u>		17. INFORMANT <u>William A. Quinlan</u> Address <u>2105 Greenery Lane Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>231X MEDIASTINAL TUMOR.</u> DUE TO (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>POSSIBLE CEREBRAL EMBOLISM.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>1-3 MONTHS</u> <u>DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 27</u> , 19 <u>67</u> , to <u>JULY 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JULY 25</u> , 19 <u>67</u> , and that death occurred at <u>8:30P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>HUGO G. GRAZIANI, MD.</u> for Dr. John Curry				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>7/22/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, MD.</u>				22d. ADDRESS <u>10101 GEORGIA AVE., S. S., MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>JULY 26, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>			
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>				25a. RECEIVED BY REGISTRAR <u>JUL 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1100-1100-1100

1100-1100-1100

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25M 1/67

<div>#17, Film 3496 6/28/76 kam MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>09846 CERTIFICATE OF DEATH 09851</div>											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 20 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11604 Georgia Avenue						d. STREET ADDRESS 11604 Georgia Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Henry Quinn						4. DATE OF DEATH Month July Day 23 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1899		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent				10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (County & State, or foreign country) Conn.			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME James Quinn						14. MOTHER'S MAIDEN NAME Louise Anger					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWII				16. SOCIAL SECURITY NO. 217-42-3750		17. INFORMANT (Wife) Jacoba S. Quinn Address 11604 Georgia Avenue Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection & Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Bladder with Metastases DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 to Present , 19, that (I) (we) last saw the deceased alive on 7-23 19 67 , and that death occurred at 5:30 P M, from causes and on the date stated above.											
22a. SIGNATURE Morris Perry						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-23-67			
22c. PHYSICIAN'S NAME (Type) Morris Perry, M.D.						22d. ADDRESS 11602 Georgia Avenue, Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR John B. Thomas ADDRESS 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.						25a. REC'D BY REGISTRAR DATE JUL 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

